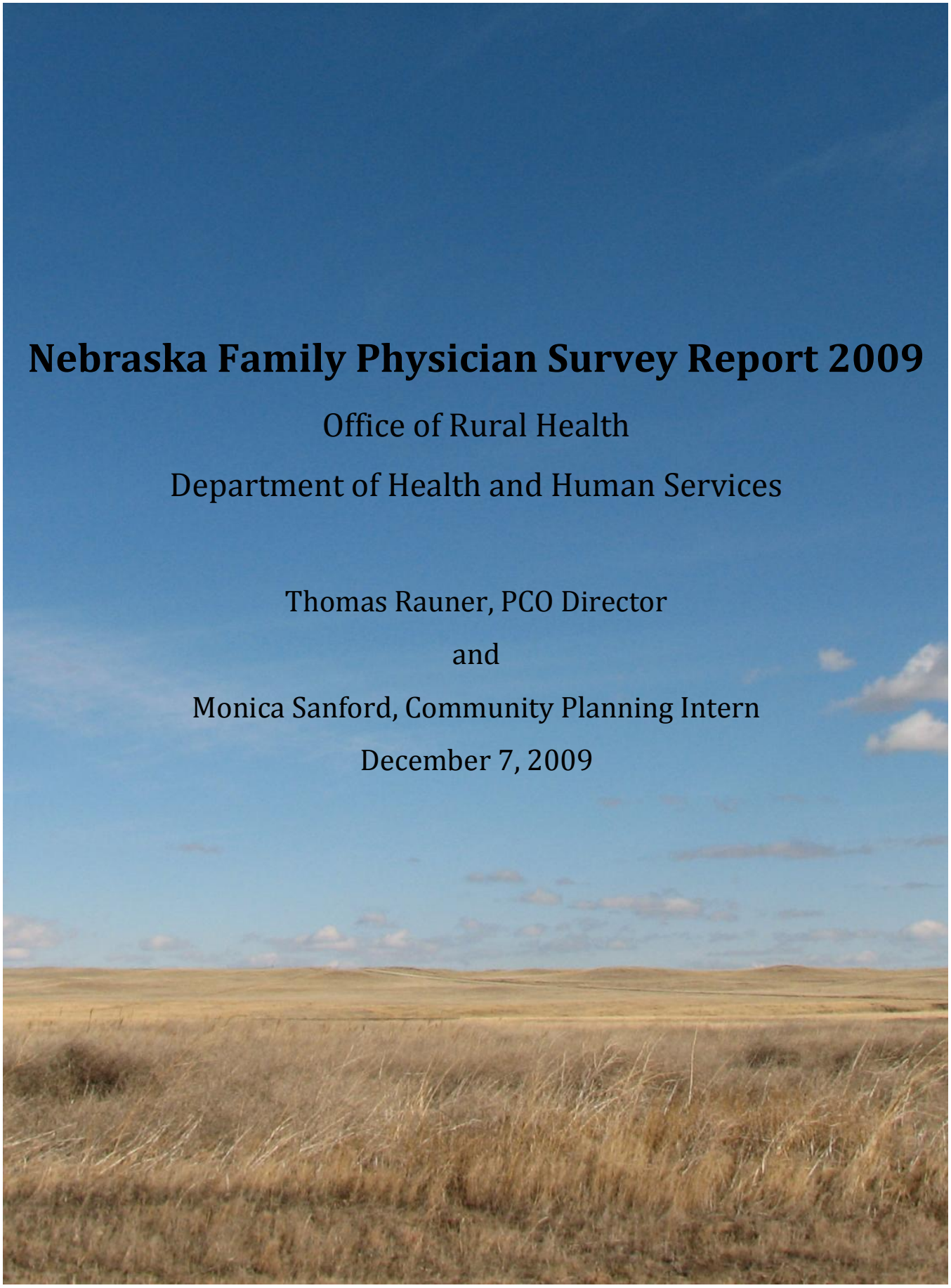


Nebraska Family Physician Survey Report 2009

Office of Rural Health

Department of Health and Human Services

Thomas Rauner, PCO Director

and

Monica Sanford, Community Planning Intern

December 7, 2009

Table of Contents

Image Credits
Cover: Sandhills in the Fort Niobrara National Wildlife Refuge, photograph taken March 2008 by Monica Sanford.

Introduction

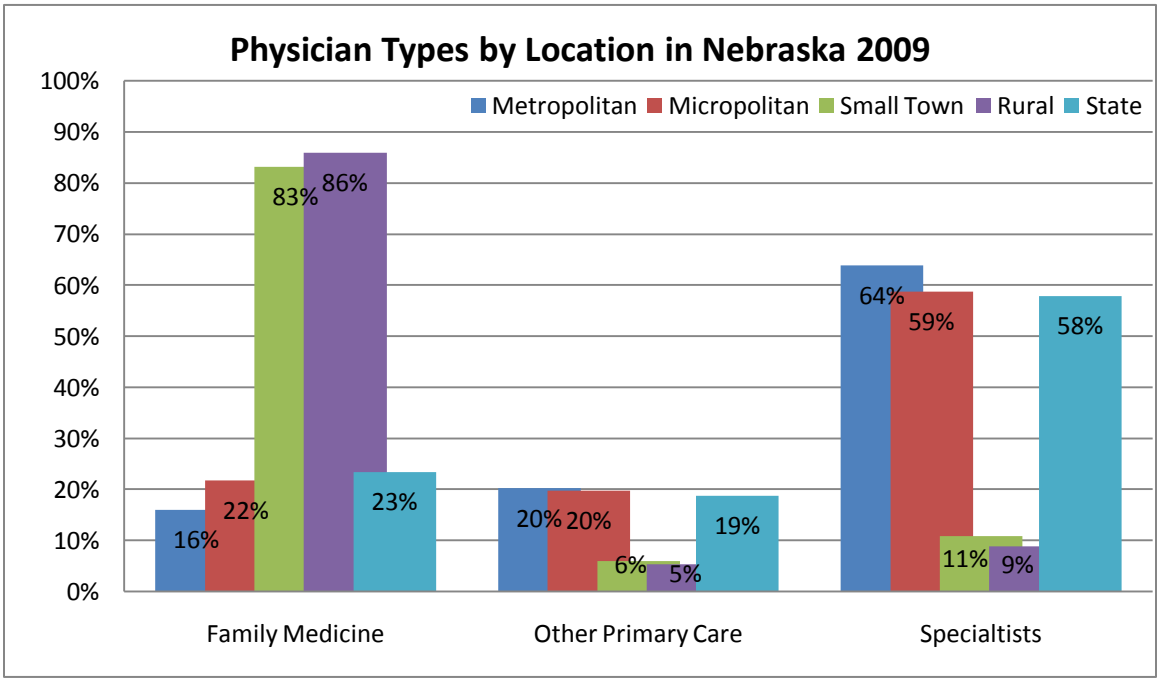
On August 31, 2009, the Office of Rural Health mailed 755 surveys to family medicine physicians in Nebraska. The list was provided by the Health Professional Tracking Service (HPTS) maintained by the University of Nebraska Medical Center. The purpose of the survey is to assess the status of family medicine in the State of Nebraska in general and rural Nebraska in particular. As of September 28, 391 (52%) of those surveys were returned. This survey has been conducted at irregular intervals in the past, the most recent being in 1995.

The Department of Health and Human Services, Office of Rural Health is concerned about the declining number of medical school graduates entering family medicine and choosing to practice in rural areas of the state. The survey was designed to understand the state of family medicine practice, physicians' plans for relocation or retirement, obstetric care practice patterns, access to and affordability of health care in rural areas, usefulness of loan repayment programs, and other issues concerning family medicine physicians in Nebraska.

Two sources of information contributed to this report: data from the HPTS database itself and the Office of Rural Health survey responses. The HPTS data consists of demographics and information regarding practice types and locations. The Office of Rural Health survey data addresses the more specific questions of tenure, obstetrics, loan repayment, and more. In the following pages these results are presented and the methods of analysis explained. More detailed information can be found in the Appendices.

The demographic analysis of family physicians was performed on the entire 755 person population, not only on the 391 survey respondents. The demographics of the population were compared to the respondent sample in order to ensure the sample was representative. It has been determined that the sample is representative as no large discrepancies were found between the two.

This survey focused on family medicine physicians as opposed to other specialties due to the high reliance on these physicians to provide medical care in small town and rural areas. The chart below demonstrates that family medicine is by far the primary specialty serving these populations.



Executive Summary

Family medicine physicians in Nebraska are three-quarters male, mostly between the ages of 36 and 60, mostly Caucasian, and all English speakers. With the exception of a high number of Asian physicians, minority physicians are underrepresented in comparison to minorities within the general population. Only 6.5% speak any language other than English and only 3% speak Spanish.

In Nebraska, 38% of family medicine physicians practice in metropolitan areas with a population of 50,000 or more. The next largest group, 30%, practice in rural areas of less than 2,500 population. An additional quarter practice in small towns of between 2,500 and 10,000 people and only 7% practice in micropolitian areas of between 10,000 and 50,000, but this may be attributed to the fact that Nebraska has few cities of this size.

Half of family medicine physicians are self-employed and practice as part of a group, while another quarter are on salary at a hospital. Most practice in a free-standing clinic (64%), while some practice in a clinic attached to a hospital (13%) and a tenth from a physician's office.

The majority (70%) intend to remain at their current locations for 7 years or more. Those who intend to leave in five years or less (63%) mostly plan to retire, while 15% intend to leave Nebraska and 14% plan to relocate either within or to an area with a population of over 20,000 people.

Most family medicine physicians are not recruiting, but almost a third are looking to hire another physician. Almost half of practices that are recruiting are in a rural area, which is disproportionate to the number of practices in rural areas, being less than a third.

Just over a third of family physicians have discontinued obstetric care while another third plan to make no changes. Close to a quarter never provided obstetric care. Of the 155 who reported they currently offer obstetric care, 20 or 13% reported their intentions to stop. Malpractice risk and cost were listed as the single largest factor contributing to the discontinuation of obstetrics, but in combination lifestyle (39%) and practice concerns (34%) had far more impact than financial concerns (19%) such as the cost of liability insurance.

Availability of rural health care is considered more of a problem than affordability of rural health care.

Physician debt upon completion of their residency has been rising steadily since the 1980's, even when adjusted for inflation. Average debt, adjusted for inflation, for physicians completing their residencies since 2000 who had some form of student debt was $125,640.

A little over a quarter of responding physicians received some form of state or federal loan repayment and generally ranked the program as very important to their decision to practice in rural areas. Physicians who did not believe loan repayment was important enough to convince them to locate in rural areas would not have taken advantage of the program.

A little over a quarter of respondents left comments on the survey. Over a quarter of those comments concerned loan repayment, likely due to the questions about loans immediately preceding the comment section. Another fifth of the comments were concerned about financial matters such a low family physician pay in relation to specialist pay scales, which was the single most frequently occurring concern. Physicians were also concerned with rural issues (18%), recruitment (16%), practice issues (7%), and various other issues (13%). In many cases, physicians felt loan repayment was important but was not by itself enough incentive to locate in rural areas given other hardships such as lower pay, longer working hours, lack of call coverage, and detriments to family life.

Survey Results

Both demographics and survey answers were analyzed using two programs: Microsoft Excel and Atlas.ti. Excel was used to count demographic categories, answers to questions, and create charts and graphs displaying the results.

Atlas.ti is software used in qualitative research, particularly in the social sciences, to analyze data which cannot be easily quantified. Atlas allows for the application of 'codes' to textual data, thereby creating categories which can be quantified and revealing relationships between the data. In this situation, Atlas.ti. was used mostly for the former function, but in a way which does not preclude a more in-depth analysis later. It was used specifically to analyze the open ended responses to Question 5, about reasons for discontinuing obstetric care, and Question 10, the open comments section.

So for example, Atlas was used to quantify how many times physicians listed malpractice risk/cost as a reason for discontinuing obstetric care. However, later we can go back and look for relationships within the data, such as whether or not male or female physicians were more likely to discontinue care for this reason, or if it was a more pressing concern for rural or urban practices, etc.

In categorizing the location of family physician practices, Rural Urban Area Commute (RUCA) codes were applied. RUCA codes were developed at the University of Washington in cooperation with the Office of Rural Health Policy of the Health Resources and Service Administration, the USDA's Economic Research Service, and a partnership between the medical school of Washington and the states of Wyoming, Alaska, Montana, and Idaho, Rural Health Research Center.

"RUCAs, Rural-Urban Commuting Area Codes, are a new Census tract-based classification scheme that utilizes the standard Bureau of Census Urbanized Area and Urban Cluster definitions in combination with work commuting information to characterize all of the nation's Census tracts regarding their rural and urban status and relationships. In addition, a ZIP Code RUCA approximation was developed," per their website http://depts.washington.edu/uwruca

For this report, the zip code data was applied to the map location of the practice. Practice locations were categorized into four general types: Metropolitan with a population of over 50,000, Micropolitan with a population between 10,000 and 49,999, Small Town with a population between 2,500 and 9,999, and Rural with a population under 2,499. A map of the RUCA areas and their physicians may be found in the Appendices.

A subset of physicians was analyzed for differences from the full population. Of the 755 family medicine physicians, 146 were identified as practicing in Medicare certified rural health clinics ("clinics"), of which 136 practice in small town or rural areas. Where differences were found, they are highlighted. If no distinction is made, it should be understood that statistics for this group match the statistics for the population or the survey sample as a whole.

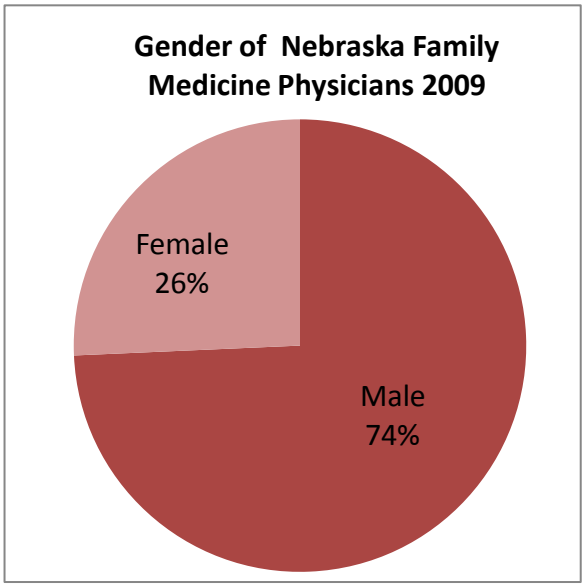
The results are presented below in both narrative and graphic form. More detailed tables and breakdown by location charts can be found in the Appendices at the end. Breakdown by location charts may have slightly different percentages due to a zip code discrepancy between the Rural Urban Commute Area (RUCA) codes and the full list of 755 physicians. Only 731 physicians could be assigned a RUCA code and the remaining 24 were omitted from the calculations. These charts are for comparison purposes only. This error does not affect the statistics for Medicare certified rural health clinic physicians.

Physician Demographics

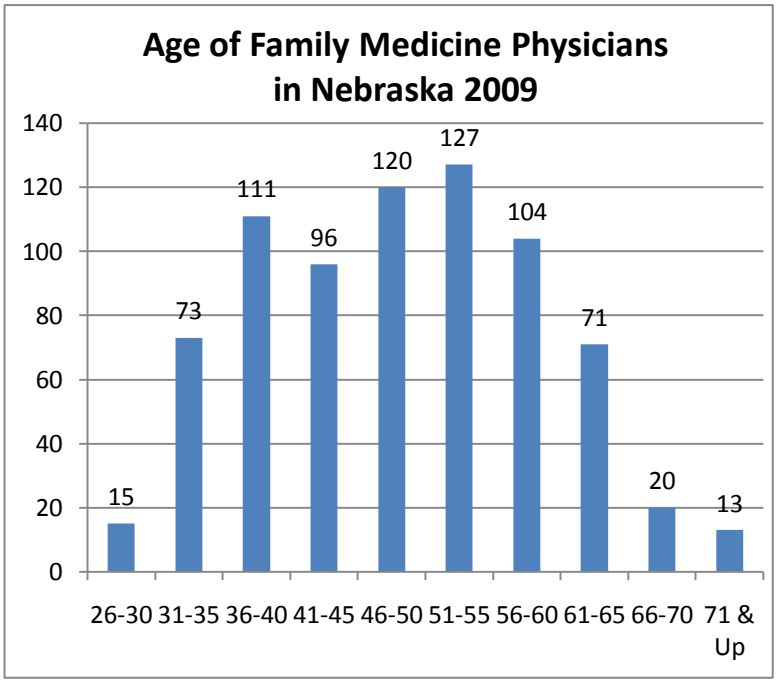
Information about gender, age, and ethnicity of family medicine physicians is available from the Health Professionals Tracking Center (HPTS) maintained by the University of Nebraska Medical Center (UNMC). Therefore, no demographic information was requested on the paper survey which was sent to the list of 755 family medicine physicians provided by the HPTS. Instead, each survey was labeled with the name and address of the physician to which it was sent, so that responses could be correlated to that exact physician upon its return. Physicians were assured of their anonymity during the reporting of results.

Demographic information was compared between the full list of physicians and those who responded to ensure data was collected from a representative sample. The response rate was just over half (51.8%) of the population, or 391 physicians out of 755. The demographic variance between the population and the sample in terms of gender, age, and ethnicity was not deemed to be significant.

The demographic variance between the population and the sample in terms of location was greater, but not detrimental to the purposes of this study. Fewer physicians in micropolitian areas and more physicians in rural areas answered the survey. As this office is primarily concerned with matters of rural health, the higher response rate from rural practitioners is appreciated. See page 9 for a more detailed breakdown of practice locations.

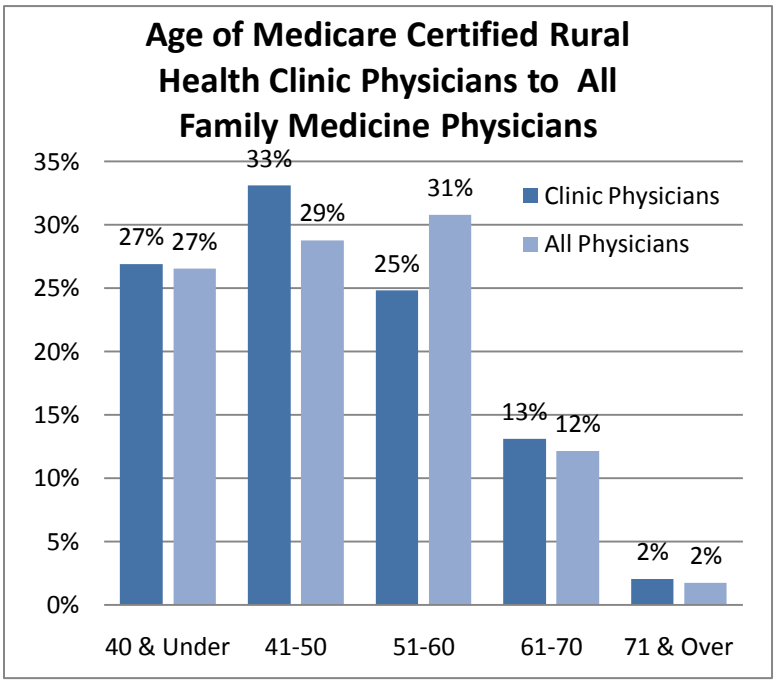


The gender breakdown of family medicine physicians in Nebraska is roughly three-quarters male (561 men to 194 women). This is an increase in females from the 1995 study, in which only a tenth of family medicine physicians were female. The gender breakdown in rural areas was approximately the same, but fewer female physicians tended to locate in small town and micropolitian areas than in metropolitan areas, where they accounted for almost a third of all family medicine physicians. The gender breakdown of rural physicians matched that of the overall population. Physicians working in Medicare certified rural health clinics were only slightly more likely (78% v. 74%) to be male. See Tables 1.0 and R1.0 in the Appendices, p. 25.

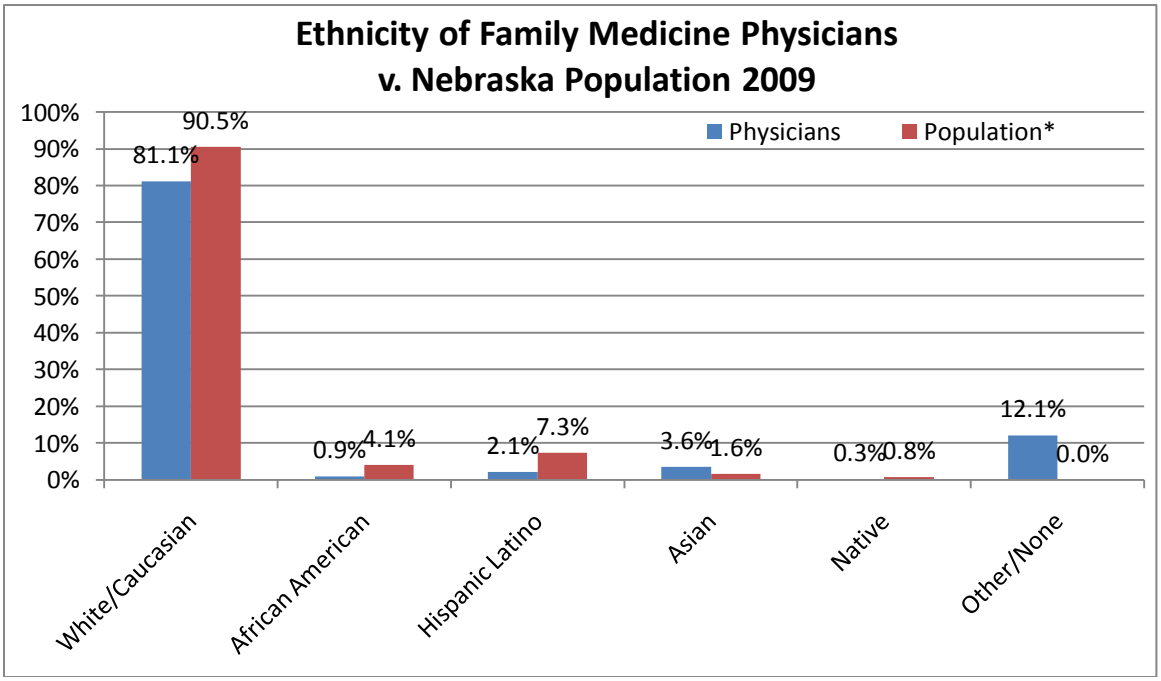


The majority of family medicine physicians (55%) are still 50 years old or younger. However, only 2% of family physicians are 30 or younger. No other five year age group is so small, and the 31-35 year old age group also shows signs of decline. This seems to confirm a trend highlighted in the comments section of the survey in which physicians worry that not enough new graduates are entering family medicine. The distribution of ages among rural physicians fluctuates in

relation to the age distribution of all family medicine physicians, especially when viewed as 5-year cohorts. When viewed as 10-year cohorts, a significant difference only appears in physicians over 50, with the 51-60 group 8% below the state distribution and the 61+ group 9% above the state distribution. However, the age distribution of small town physicians is not significantly different from the state distribution. While only 44% of family medicine physicians are over age 50, 60% of those working at Medicare certified rural health clinics are under 50. See Tables 2.0 and R2.0 and Age Breakdown by Location Chart in the Appendices, p.25-26.



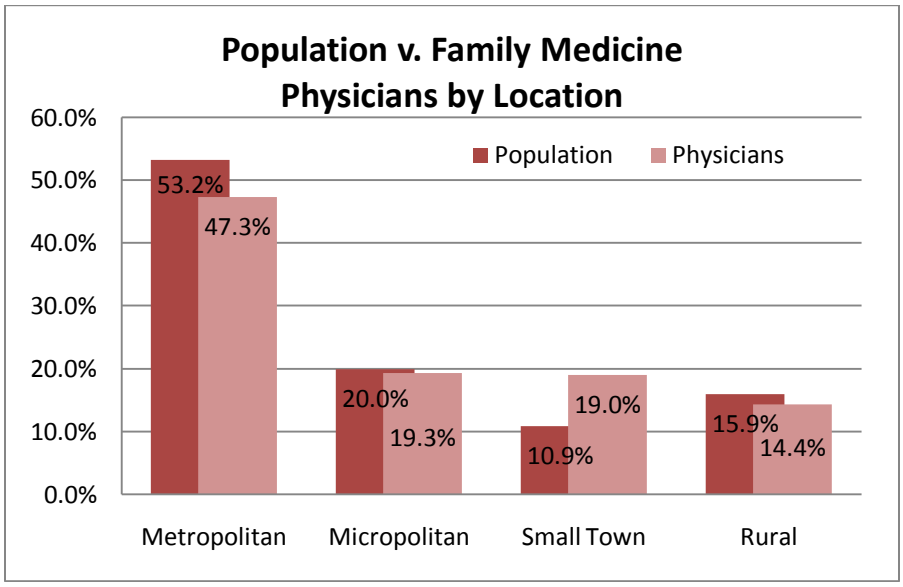
The vast majority (81.1%) of family medicine physicians identify themselves as White/Caucasian. The most common minority among physicians are those of Asian ethnicity (3.6%), most being of East Asian decent (2.5%) and some of Central Asian origin (1.1%). Asian family medicine physicians are more common than the occurrence of Asians in the general Nebraska population, while African American/Black and Hispanic/Latino physicians are less common than their general population counterparts. It should be noted that a full 12.1% of respondents marked their ethnicity as 'Foreign,' 'Other,' 'Unknown,' or 'No Response.' Whereas, in the U.S. Census data from which the general population statistics are acquired, this is not an option. Rural physicians were more likely by 7% to be White/Caucasian, while metropolitan physicians were less likely by 6% to be White/Caucasian. All minority physicians were slightly less likely to locate in rural and small town areas and more likely to locate in metropolitan areas. See Tables 3.0, 3.1 and Ethnicity Breakdown Chart in the Appendices, p. 25.



The majority, 92.5%, of Nebraska family medicine physicians speak only one language. Only 6.5% speak two and 1.1% speak three languages or more. All family medicine physicians in Nebraska speak English. Only 3% speak Spanish and 5% speak one or more of 23 other languages. For comparison, 4.3% of Nebraskans speak English 'less than well' according to the U.S. Census Bureau and 3.1% of the population speaks English 'less than well' and speaks Spanish in the home.

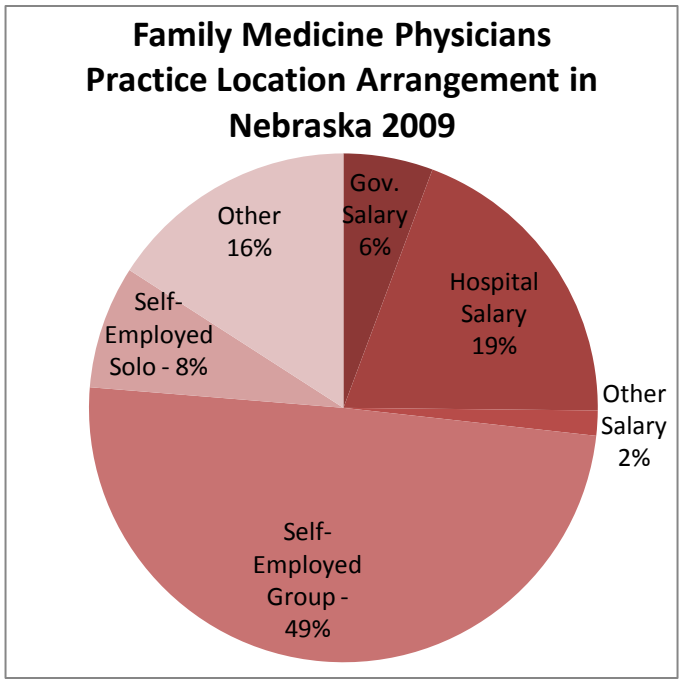
Languages Spoken			
	English	Spanish	Other
Physicians	755	23	41
Percentage	100%	3%	5%

Naturally, most physicians are located in metropolitan areas with populations of 50,000 or greater. A corresponding number of physicians practice in micropolitian areas with populations between 10,000 and 49,999. However, more physicians practice in small towns with populations of between 2,500 and 9,999 than in rural areas with populations of 2,499 or less, than the number of people who live in these areas. For the purpose of this analysis, we applied Rural Urban Area Commute (RUCA) codes to each Nebraska zip code to determine if it is a metropolitan, micropolitian, small town, or rural area. These were developed in collaboration by the federal Health Resources and Service Administration, the USDA, and the University of Washington. See Table 4.0 in the Appendices, p. 26. This analysis indicates that physicians locate their practices in small towns in far greater numbers than those in isolated rural towns. This is likely due to the rural issue concerns expressed in the Comments section.

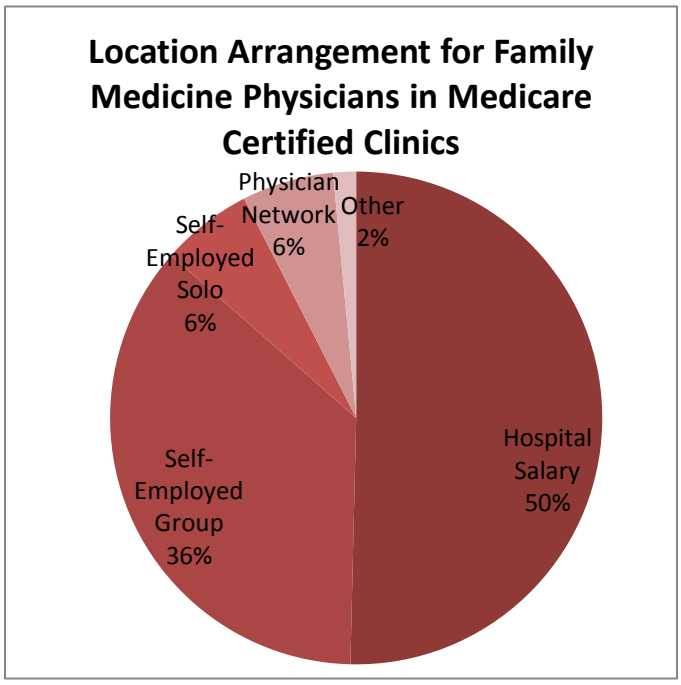


Practice Arrangements

Close to half (49%) of family medicine physicians in Nebraska are self employed as part of a group or partnership. Close to a fifth are employed by non-federally operated hospitals on a salaried basis. Other types of employment include locum tenens and working as part of a physician network. Just over a tenth of physicians did not have a practice location arrangement listed. Medicare certified rural health clinic physicians are more likely (50% v. 24%) to work for the local hospital. See Tables 5.0 and R5.0 and Practice Arrangement Breakdown by Location Chart in the Appendices, p. 26-27 for more detailed information.



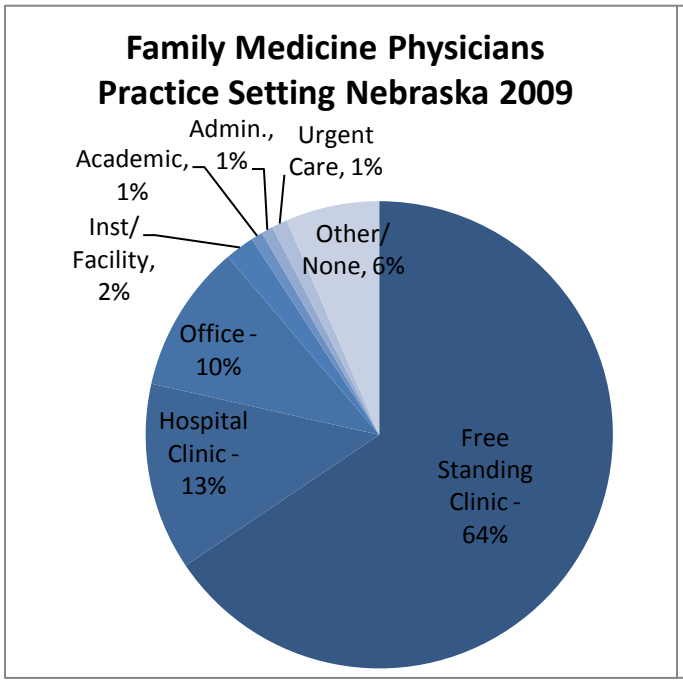
Most (69%) family medicine physicians practice in a free standing clinic while smaller percentages work in a clinic that is attached to a hospital or a separate physicians' office. Only a small percentage work in other settings, such as at medical schools or teaching hospitals, government or industrial facilities, or in public health. Medicare certified rural health clinic physicians were more likely to work in a clinic attached to a local hospital. See Tables 6.0 and R6.0 in the Appendices, p. 27, for more detailed information.

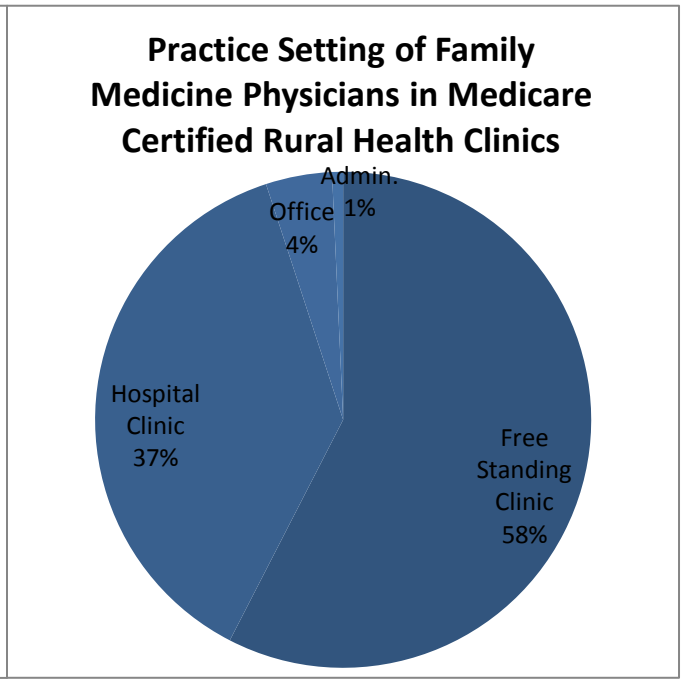


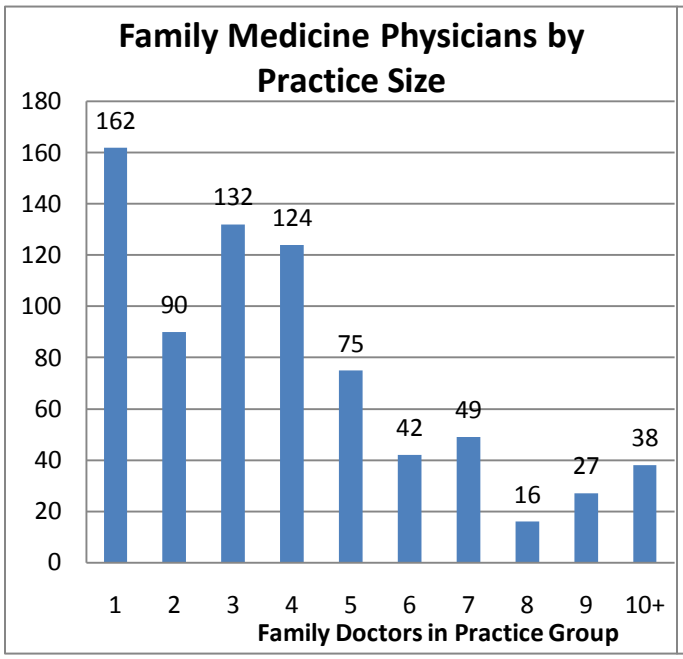
The vast majority of physicians, 81%, work full time, while 11% work less than 30 hours a week, and 7% work between 30 and 39 hours per week. See Table 7.0 in the Appendices for more detailed information.

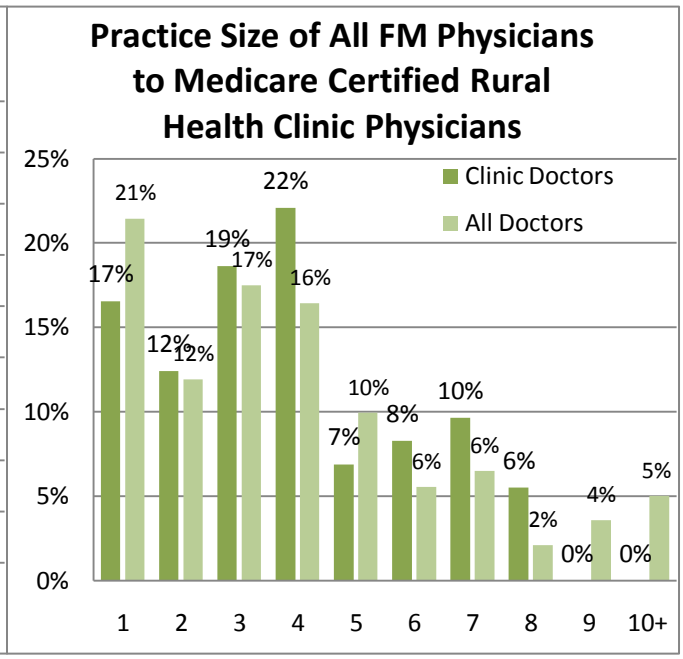
A significant number of physicians work in a practice with only one family medicine physician, though other specialists, physicians assistants, or nurse practitioners may be on staff. Rural physicians are more likely to be in a self-employed solo practice (+7%) than any other cohort, although small town physicians are more likely to be part of a self-employed group (+5%). Medicare certified rural health clinic physicians are less likely to practice alone and more commonly practice as part of a 2 to 4 physician clinic than do other family medicine physicians. See Practice Arrangement Breakdown by Location Chart in the Appendices, p. 28 and p. 11.

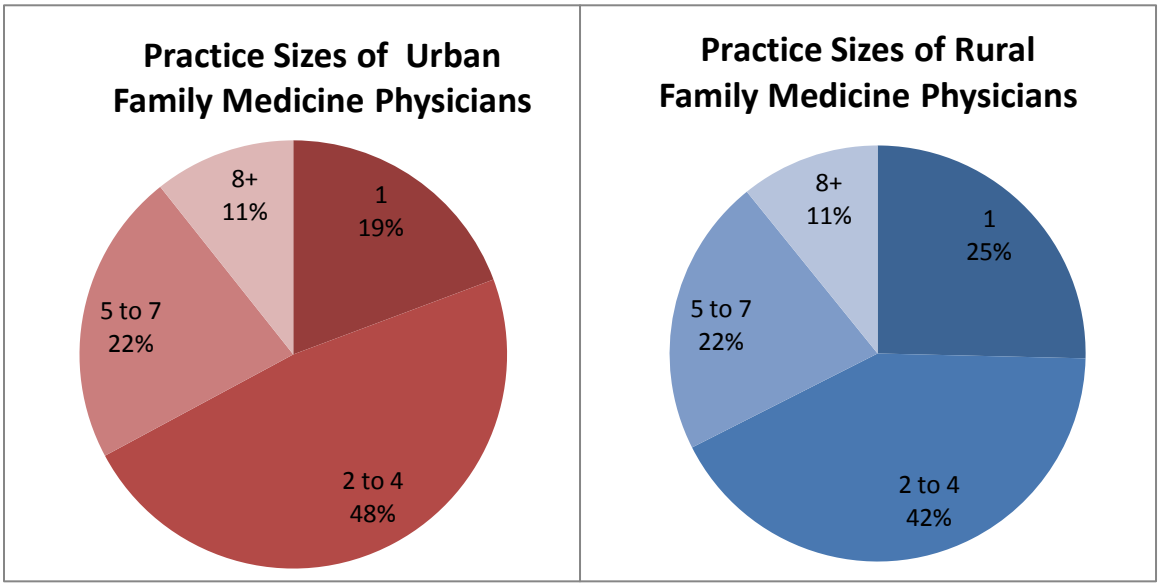
Average tenure at a practice location was a little over 18 years. Average tenure at Medicare certified rural health clinics was only a little under 18 years.

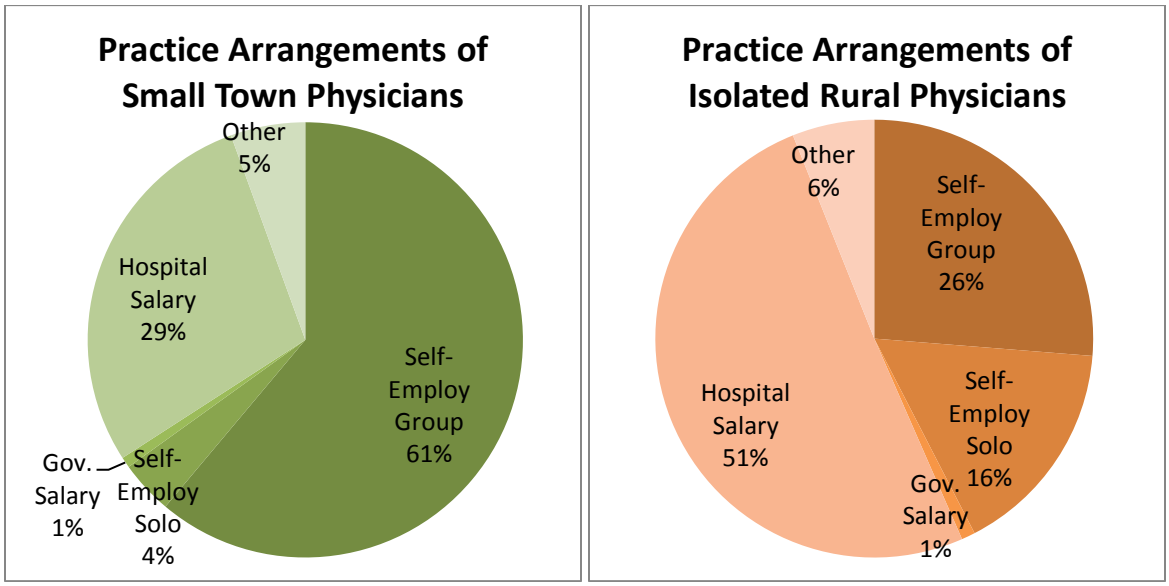

Family Medicine Physicians Practice Setting Nebraska 2009
Admin., 1%
Urgent Care, 1%
Academic, 1%
Inst/ Facility, 2%
Other/ None, 6%
Office - 10%
Hospital Clinic - 13%
Free Standing Clinic - 64%


Practice Setting of Family Medicine Physicians in Medicare Certified Rural Health Clinics
Admin. 1%
Office 4%
Hospital Clinic 37%
Free Standing Clinic 58%

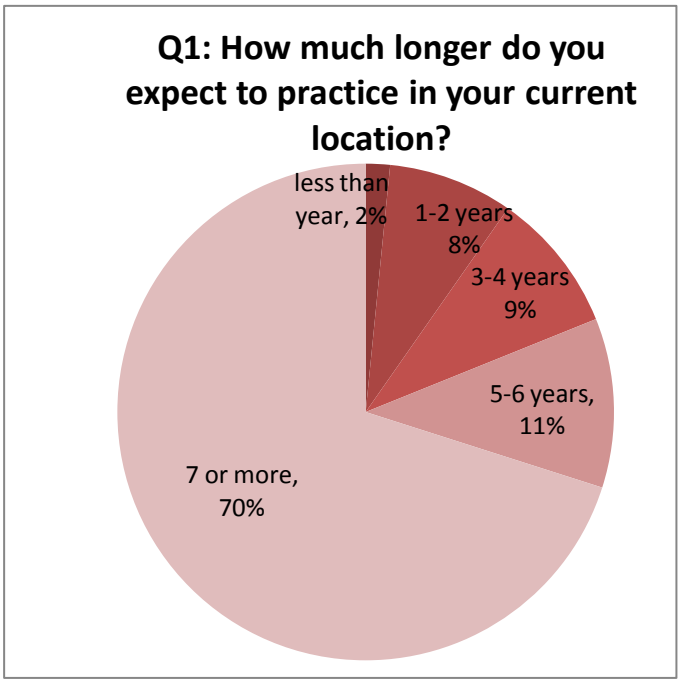

Family Medicine Physicians by Practice Size
180
160
140
120
100
80
60
40
20
0
162
90
132
124
75
42
49
16
27
38
1 2 3 4 5 6 7 8 9 10+
Family Doctors in Practice Group


Practice Size of All FM Physicians to Medicare Certified Rural Health Clinic Physicians
25%
20%
15%
10%
5%
0%
Clinic Doctors
All Doctors
17% 21%
12% 12%
19% 17%
22% 16%
7% 10%
8% 6%
10% 6%
6% 2%
0% 4%
0% 5%
1 2 3 4 5 6 7 8 9 10+

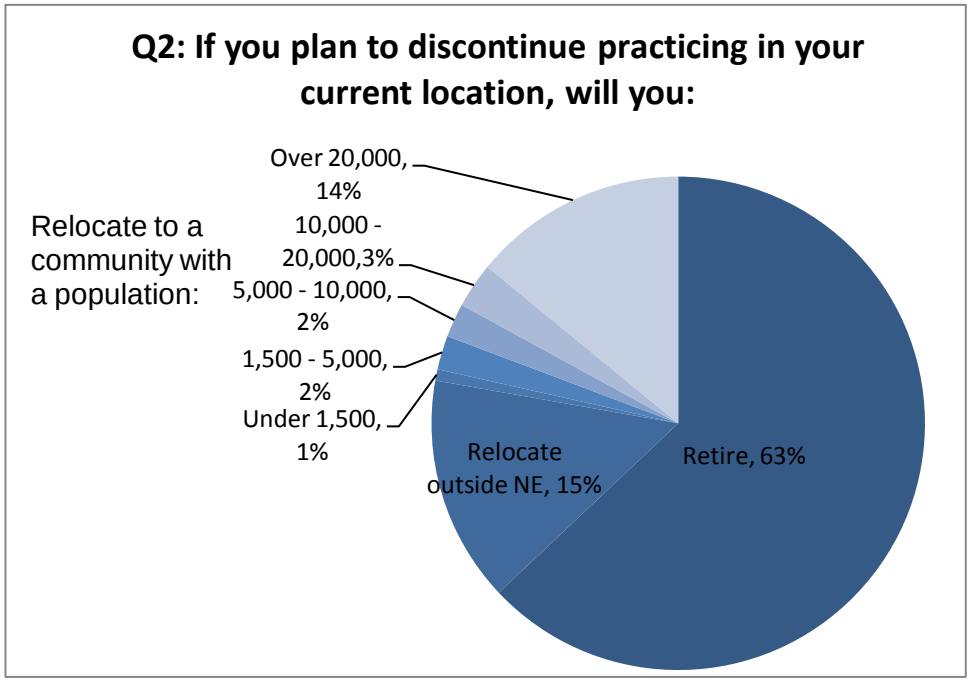

Practice Sizes of Urban Family Medicine Physicians
1 19%
2 to 4 48%
5 to 7 22%
8+ 11%
Practice Sizes of Rural Family Medicine Physicians
1 25%
2 to 4 42%
5 to 7 22%
8+ 11%


Practice Arrangements of Small Town Physicians
Other 5%
Hospital Salary 29%
Self-Employ Group 61%
Gov. Salary 1%
Self-Employ Solo 4%
Practice Arrangements of Isolated Rural Physicians
Other 6%
Self-Employ Group 26%
Hospital Salary 51%
Self-Employ Solo 16%
Gov. Salary 1%

Physician Migration



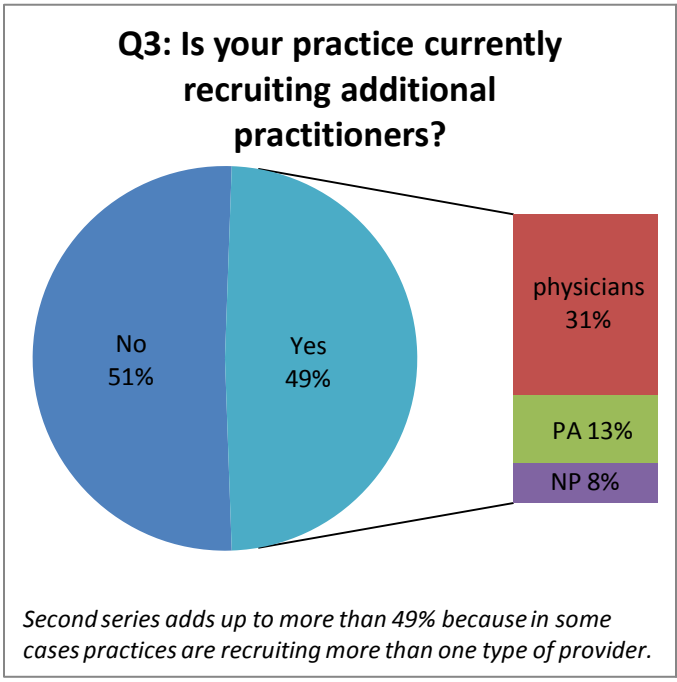
The vast majority of family medicine physicians in Nebraska (70%) indicated they intend to stay in their current practice location for seven or more years. Less than 2% intend to leave within the year. There was no significant difference in responses from Medicare certified rural health clinic physicians, however, rural physicians overall had the smallest portion (63%) who indicated that they would be staying in their current location for 7 years or more. A slightly higher percentage indicated they would be discontinuing practice within 3-4 or 5-6 years, most in order to retire. See Tables Q1 and RQ1 and Q1 Responses by Location Chart in the Appendices, p. 28-29 for more detailed information.



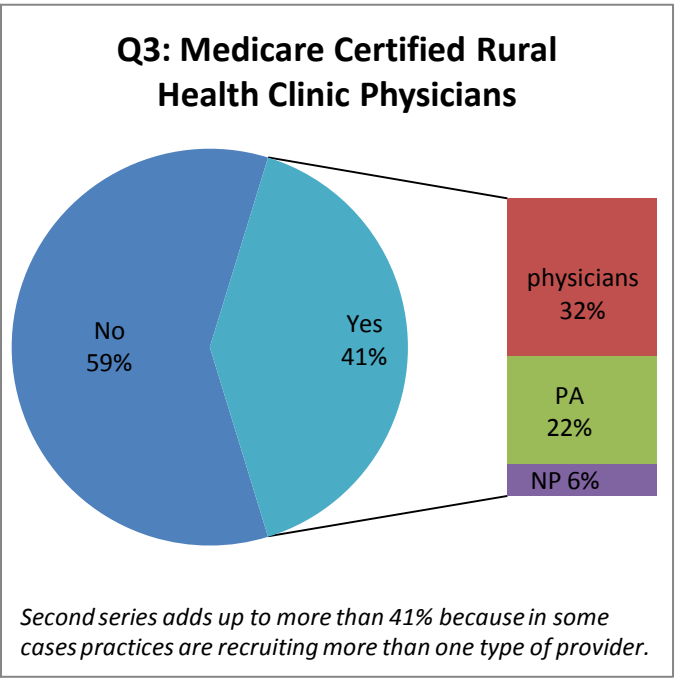
Physicians who do intend to leave are most likely (63%) to retire, while 15% indicated their desire to relocate outside the state and 14% indicated they would relocate either to or within a city with a population of over 20,000 people. See Table Q2 in the Appendices for more detailed information. Only a fifth of those relocating to/within a city of over 20,000 are relocating from a smaller area. Of those intending to leave the state, 42% currently practice in rural areas with a population of under 2,500. Equal numbers (29%) intend to leave metropolitan and micropolitian regions, while no physicians currently practicing in small towns indicated their intention to leave Nebraska. There was no significant difference in responses from Medicare certified rural health clinic physicians, but rural physicians in general were more likely to indicate they intended to retire (+9%) or relocate outside Nebraska (+3%) than any other group. See the Q2 Responses by Location Chart in the Appendices, p. 29-30.

Practitioner Recruitment

Most practices (59%) are not currently recruiting. Over a third are recruiting physicians, while 13% are recruiting physicians assistants, and 8% are recruiting nurse practitioners. Fewer Medicare certified rural health clinics are recruiting, but those that are recruiting are more likely to be seeking more than one type of health care professional. Specifically, Medicare certified rural health clinics are recruiting more physician's assistants. These clinics are required to have a physician's assistant, nurse practitioner or certified nurse midwife on staff. See Table Q3 in the Appendices, p. 29, for more detailed information.



Second series adds up to more than 49% because in some cases practices are recruiting more than one type of provider.

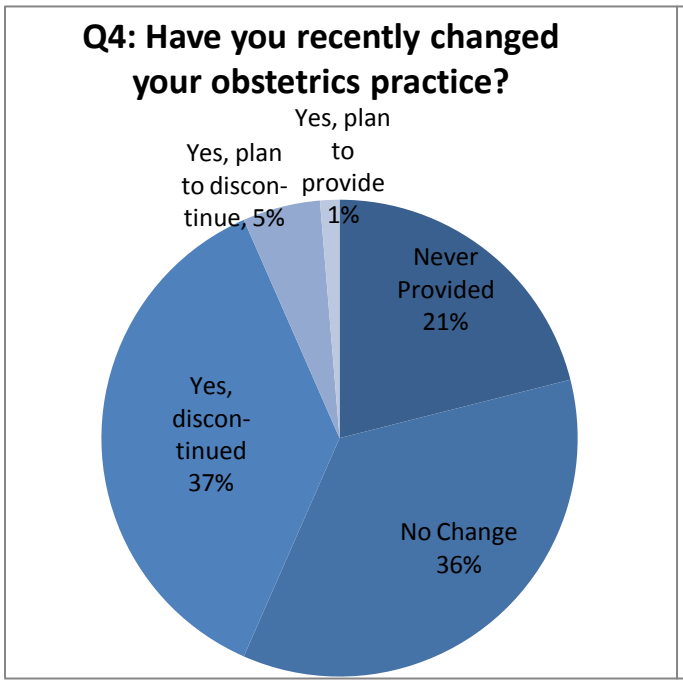


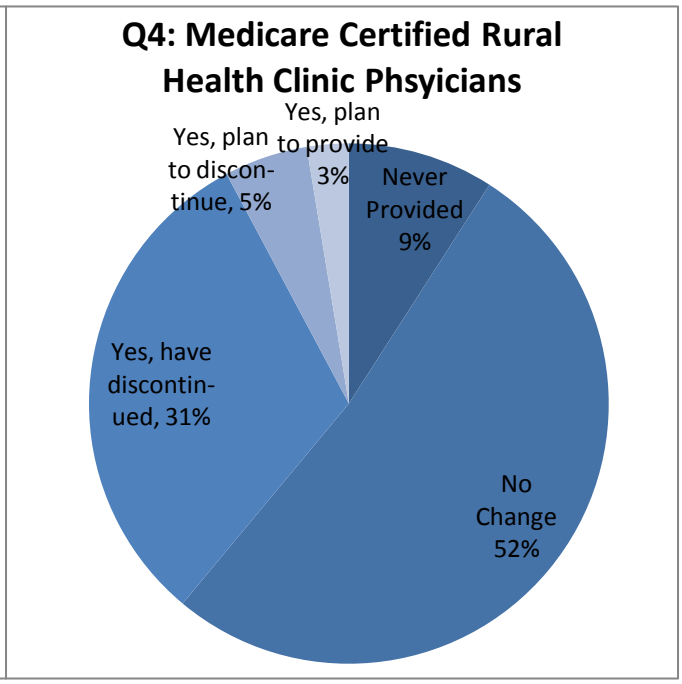
Second series adds up to more than 41% because in some cases practices are recruiting more than one type of provider.

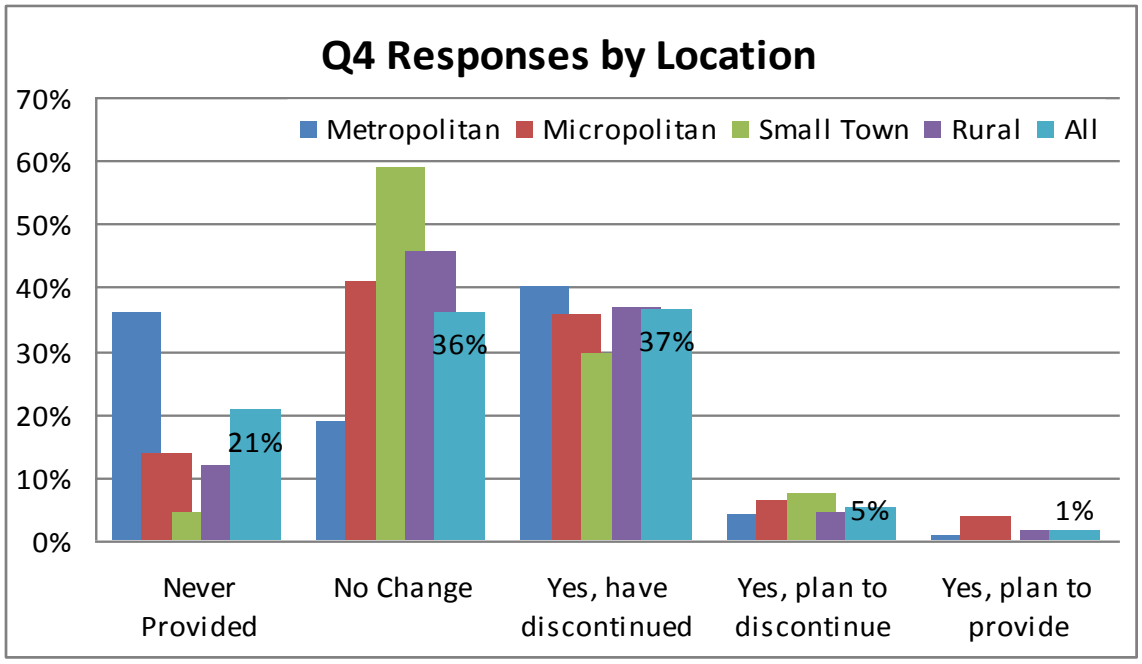
Of those practices which are recruiting, 47% are located in rural areas with populations under 2,500 people. None are located in small towns, 15% are in micropolitian areas, and 37% are in metropolitan areas.

Obstetric Care Access

Over a third (37%) of family medicine physicians have discontinued obstetric care sometime in the past. Another third (36%) intend to make no changes and continue offering obstetric care for the foreseeable future. Over a fifth (21%) have never provided obstetric care. Urban physicians were far more likely to have discontinued care than rural physicians, likely due to the availability of OB/GYN specialists. Physicians in Medicare certified rural health clinics are far more likely to have provided and will continue providing obstetric services, likely due to the lack of OB/GYN specialists in those areas. This generally matches trends for all small town and rural physicians, not just those working at rural health clinics. See Tables Q4 and RQ4 in the Appendices, p. 30, for more detailed information.

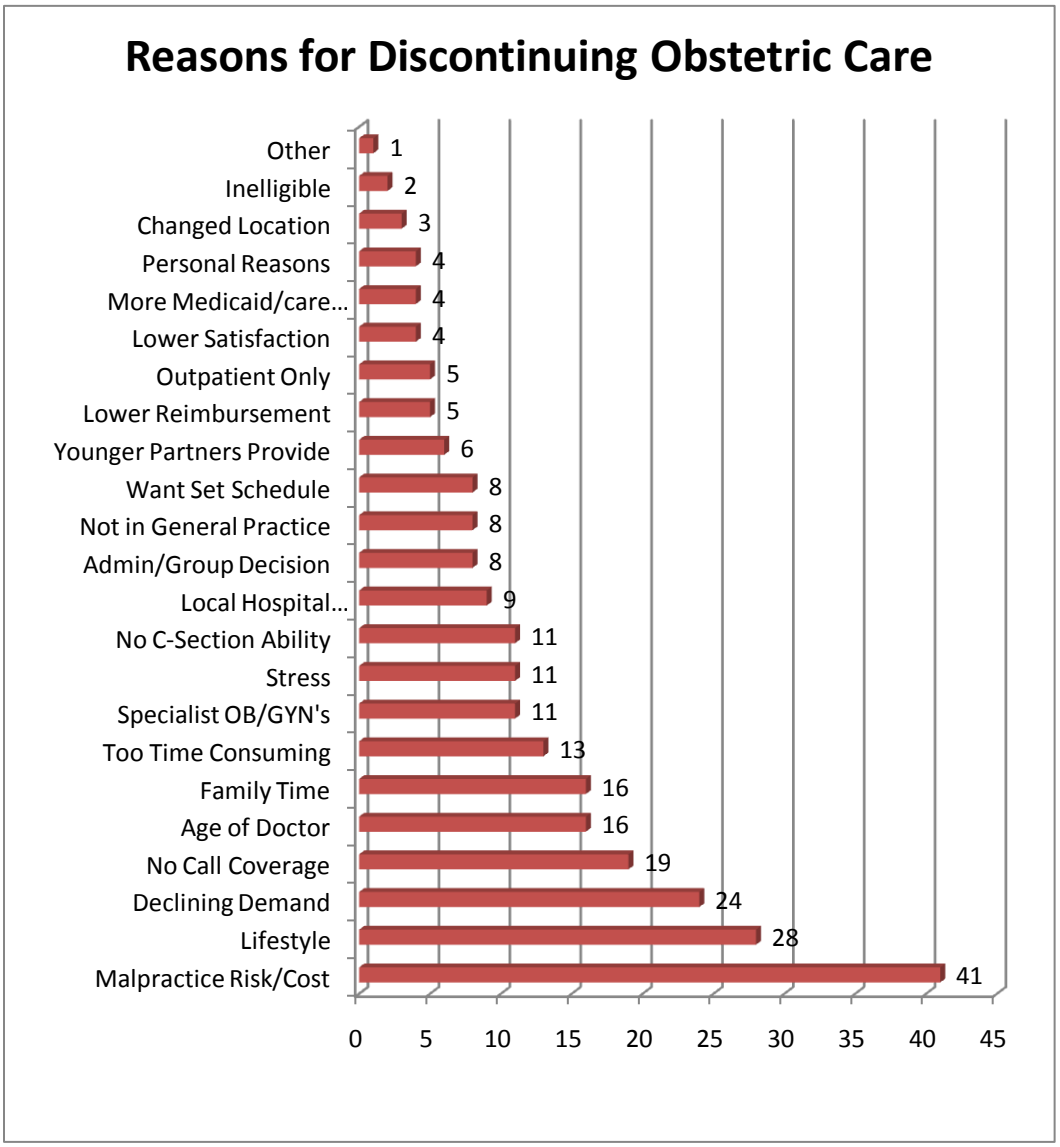


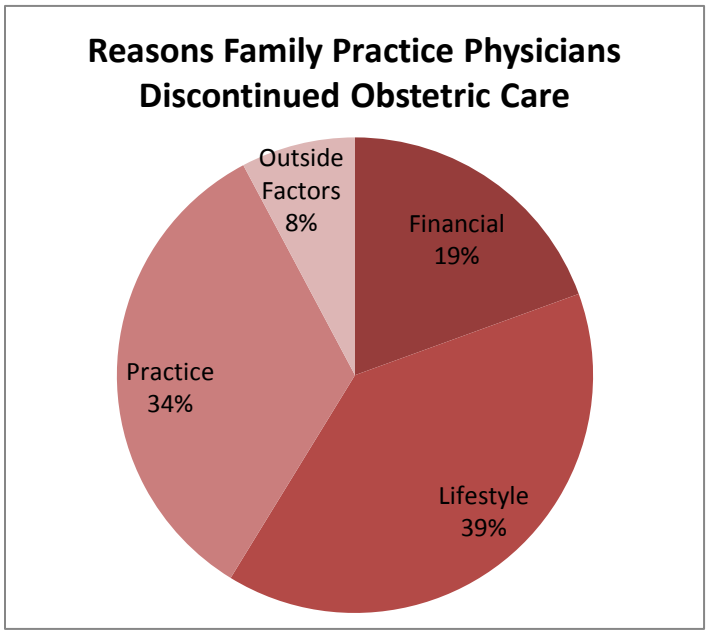




Many family medicine physicians have discontinued obstetric care in the recent past. Of the survey respondents, 181 (46%) provided comments as to why they discontinued or were considering discontinuing obstetric care. The results were put through a qualitative analysis using the Atlas.ti software as discussed in the Survey Results section.

The most commonly cited reason was due to the malpractice risk and associated cost of malpractice insurance, which appeared in the comments 41 times, or for about 23% of the responding physicians. Physicians often cited multiple reasons for ending their obstetric practice. The next most common reason given was the generic term "lifestyle" appearing 28 times, followed by declining demand at 24 times, and no call coverage at 19 times. All in all, 23 separate codes appeared in the analysis. These can be viewed as different concerns or reasons for discontinuing care. See the graph below for a full listing.

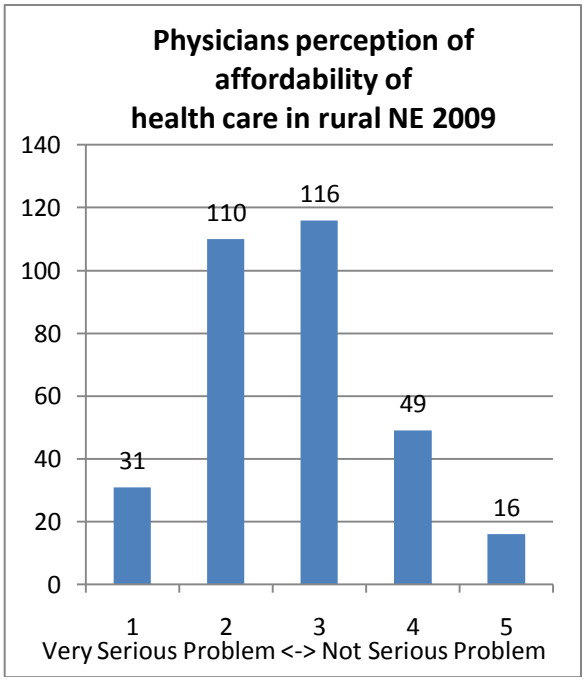


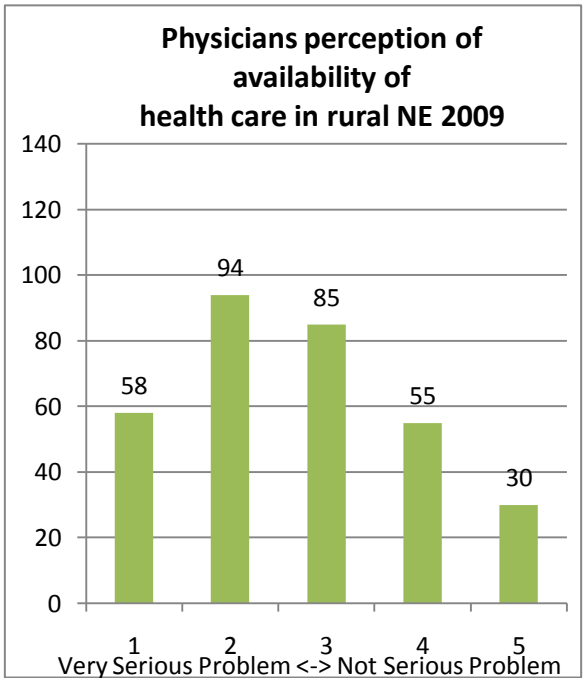


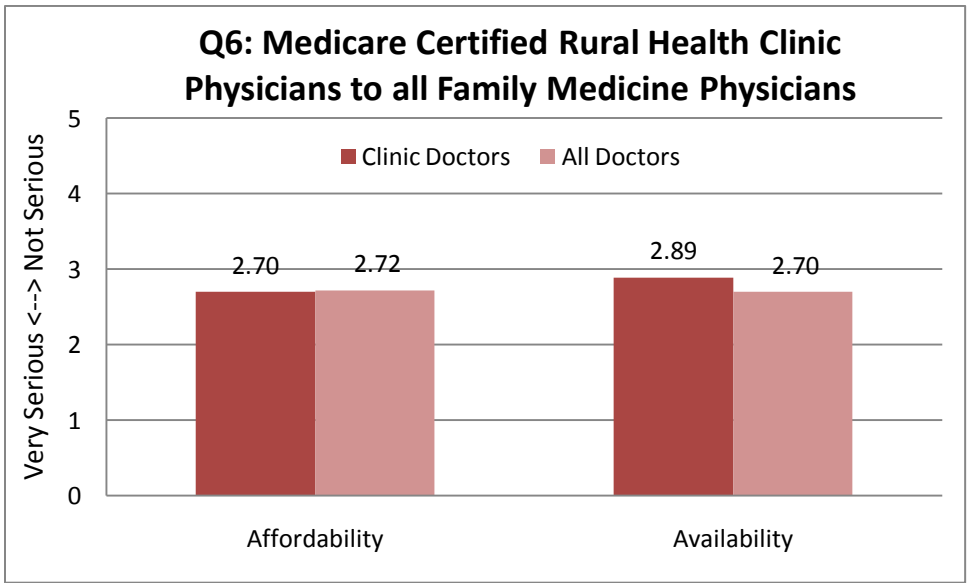
While malpractice risk/cost was by far the most common single factor, if we group the reasons into categories, we can see that lifestyle factors, such as the age of the physician, wanting to spend more time with one's own family, stress, and the desire for a set schedule (as well as the generic response 'lifestyle'), occurred far more often than financial concerns such as malpractice risk/cost and lower reimbursement. Practice considerations, such as a decline in demand for such services, lack of on-call coverage, inability to perform a C-section under anesthesia, and providing outpatient care only were also more common than financial concerns. Comments made by Medicare certified rural health clinic physicians were not analyzed separately.

Health Care Access

Family medicine physicians are divided in their perceptions of how serious the problems of affordability and availability of health care access are in rural Nebraska. On a scale of one to five where one was "Very Serious" and five was "Not at all Serious," the average rating for affordability was 2.72 and the average rating for availability was 2.70. However, a further breakdown reveals that close to half of physicians (44% and 47% respectively) chose either one or two, indicating their belief that both affordability and availability are serious problems facing rural health care. Physicians practicing in rural areas were slightly more likely to perceive both problems as serious, with an average rating of 2.82 for availability and 2.78 for affordability. There was very little difference between the perceptions of clinic physicians and all family medicine physicians on these issues. See Tables Q6, RQ6, Q6a, and Q6b in the Appendices, p. 31-32, for more detailed information.



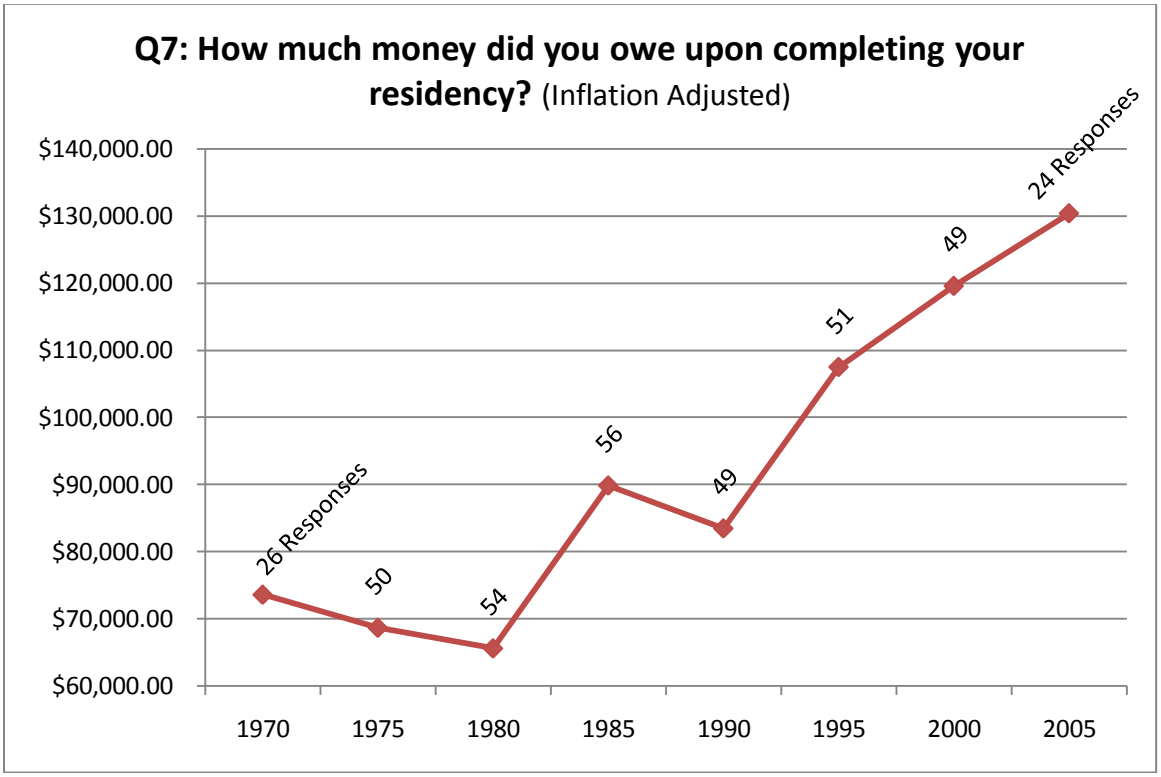


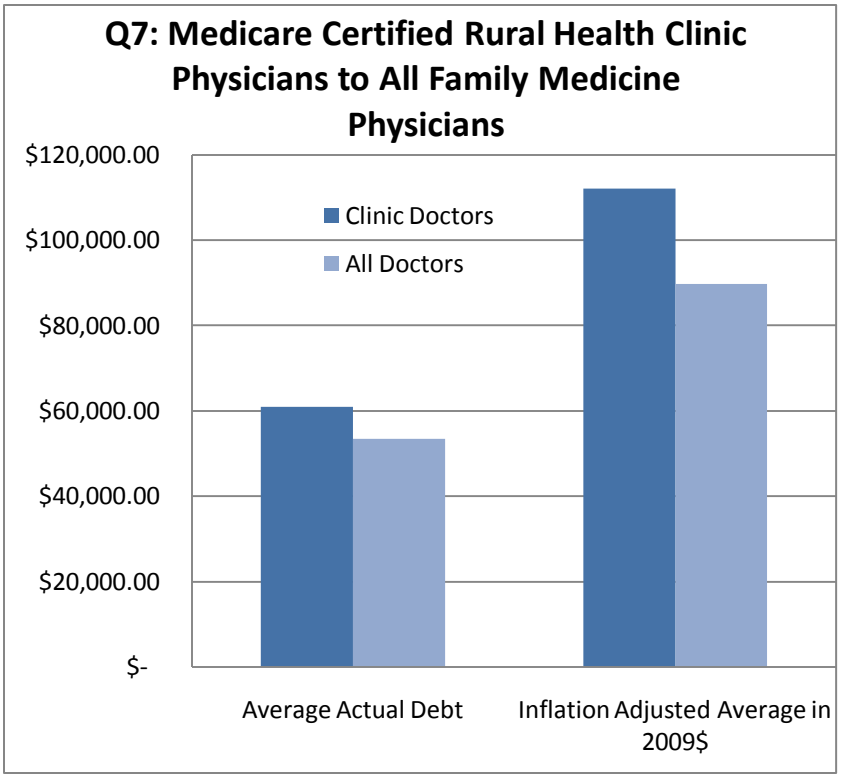


Student Debt

Family medicine physicians who responded to the survey (391) provided an estimation of their total student debt upon completion of their residency. The average actual debt was $53,397.89. However, this figure is of little value considering that some physicians completed their residency up to 50 years ago. Therefore, the debt figures were adjusted for inflation using the physician's age minus 28 years (on the assumption that most physicians complete their residency by the age of 28) to estimate the year in which the physician completed their residency. Figures were then adjusted for inflation, resulting in an average debt in 2009 dollars of $89,735.63. Medicare certified rural health clinic physicians were likely to have a significantly higher debt than other physicians, averaging $112,121.78 when adjusted for inflation. See Table RQ7 in the Appendices, p. 33, for more detailed information.

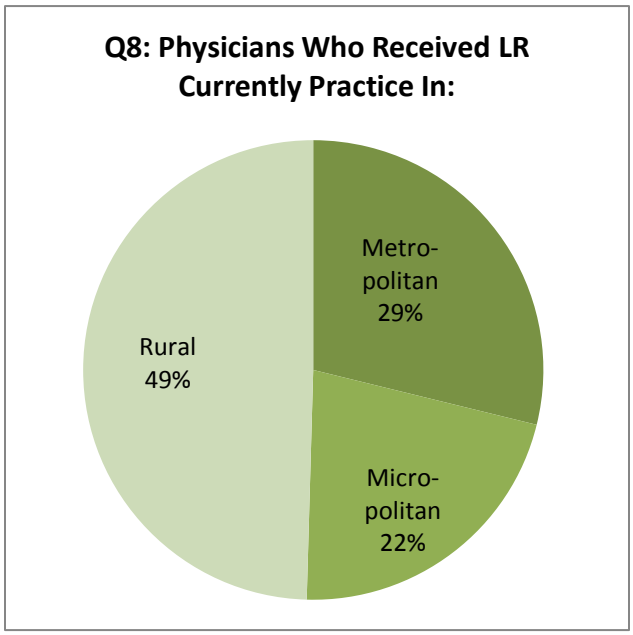
However, this figure is an absolute average which includes all those physicians who were debt free upon completion of their residency. If we include only the physicians with some debt, we find the average inflation adjusted debt of physicians with student loans was $181.423.68 upon completion of their residency. We can then see that even adjusted for inflation, physicians' student debt has been rising steadily. A cursory examination of surveys completed by physicians who finished their residencies in the early 1950's, late 1970's, and early 1980's shows that many of them noted a lack of debt due to military benefits, likely corresponding with the end of World War II and the Vietnam War. Only one physician completing residency in the 1950's and four physicians in the 1960's provided information, therefore, the only worthwhile conclusions can be drawn for the trend beginning in the 1970's. Average debt adjusted for inflation of physicians who completed their residencies since 2000 and had some form of student debt was $125,640.

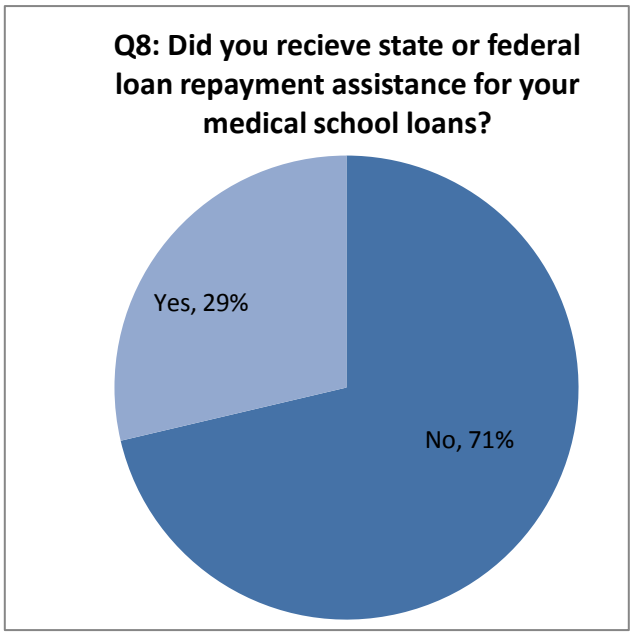



Q7: Medicare Certified Rural Health Clinic Physicians to All Family Medicine Physicians
$120,000.00
$100,000.00
$80,000.00
$60,000.00
$40,000.00
$20,000.00
$-
Clinic Doctors
All Doctors
Average Actual Debt
Inflation Adjusted Average in 2009$

Loan Repayment

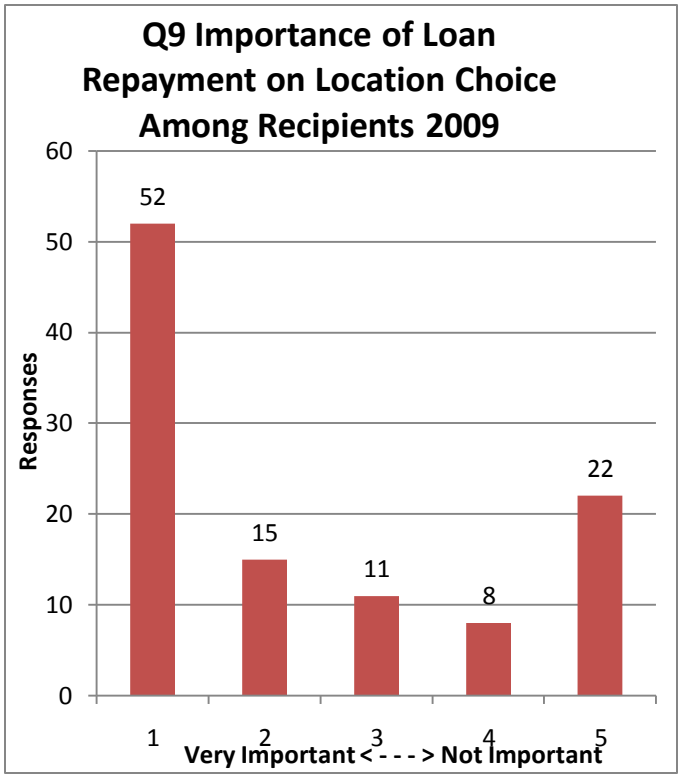
Almost of third (29%) of family medicine physicians in Nebraska took advantage of some kind of federal or state loan repayment program. Responses from Medicare certified rural health clinic physicians were evenly split with 40 each responding yes or no to whether they received state or federal loan repayment. Rural and small town physicians in general were far more likely (+24% & +19%) to have received loan repayment than metropolitan and micropolitian physicians (-14% & -11%). See Tables Q8 and Q8 Responses by Location Chart in the Appendices, p. 32-33, for more detailed information.





When asked to rank how important loan repayment was in their decision to practice in a rural location, with one being "Very Important" and five being "Not at all Important," those who received loan repayment gave it an average rating of 2.38. Medicare certified rural health clinic physicians gave it an average of 2.18. Most (62%) felt that loan repayment was an important factor in their decision to practice in a rural area. See Table RQ9 in the Appendices, p. 33.

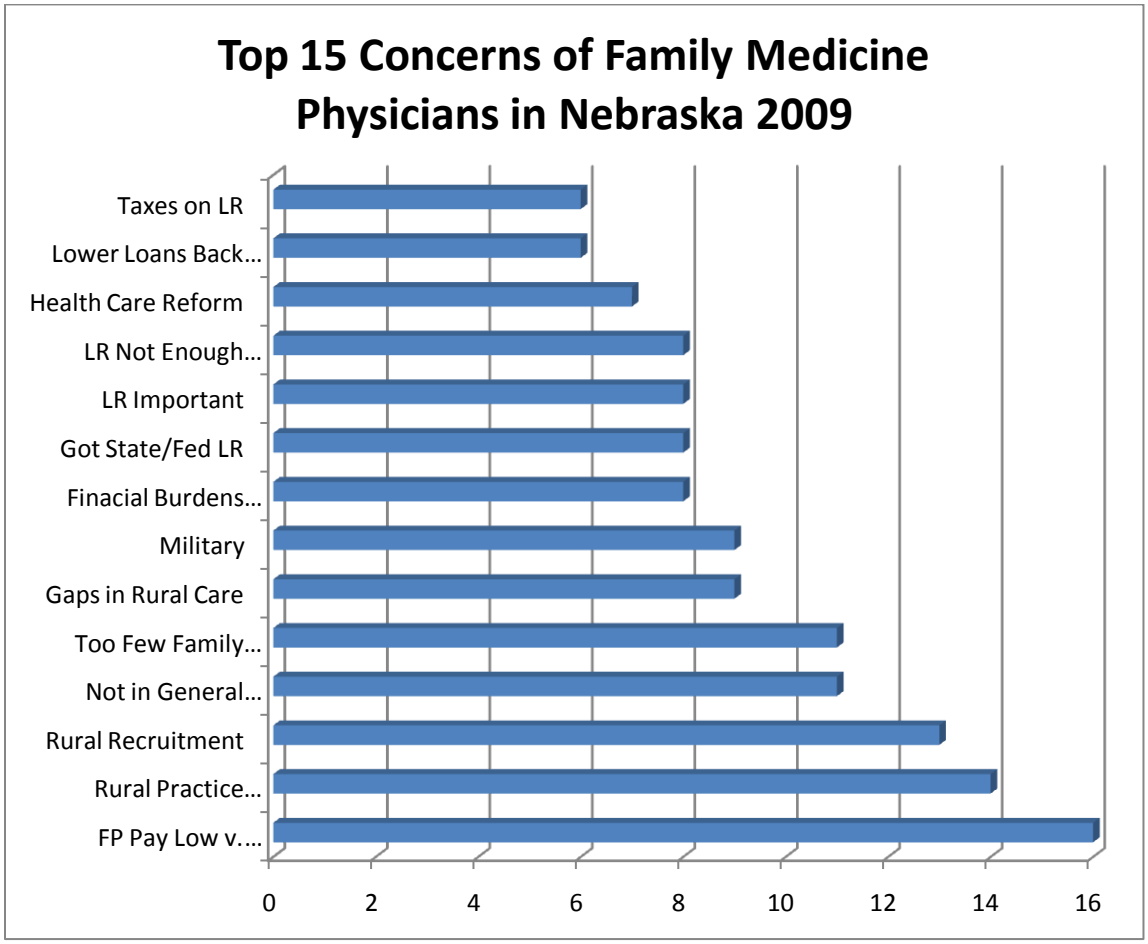
Of those who did not receive loan repayment, 17% still answered this question, giving it an average rating of 4.22. This may indicate that they were aware of the loan repayment programs for practicing in rural areas but chose not to take advantage of them because they either felt loan repayment was unimportant to their decision making or other considerations took precedence. See Tables Q9 and Q9a and Q9 by Location Chart in the Appendices, p. 33, for more detailed information.



Comments

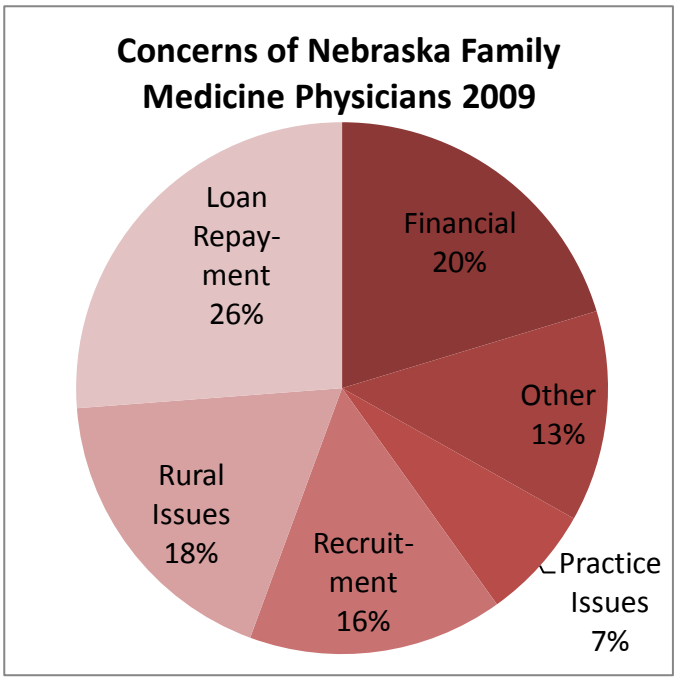
Of the responding physicians, 115 (29%) left comments. These comments were put through a quantitative analysis using the Atlas.ti software as discussed in the Survey Results section. Thirty-seven different codes or areas of concern were identified, the most common being the lower reimbursement of family medicine physicians especially when compared to specialist physicians. However, the comments from this section where much more diverse than those supplied to the more specific question concerning obstetric care. Only 14% of respondents cited low pay as a concern.

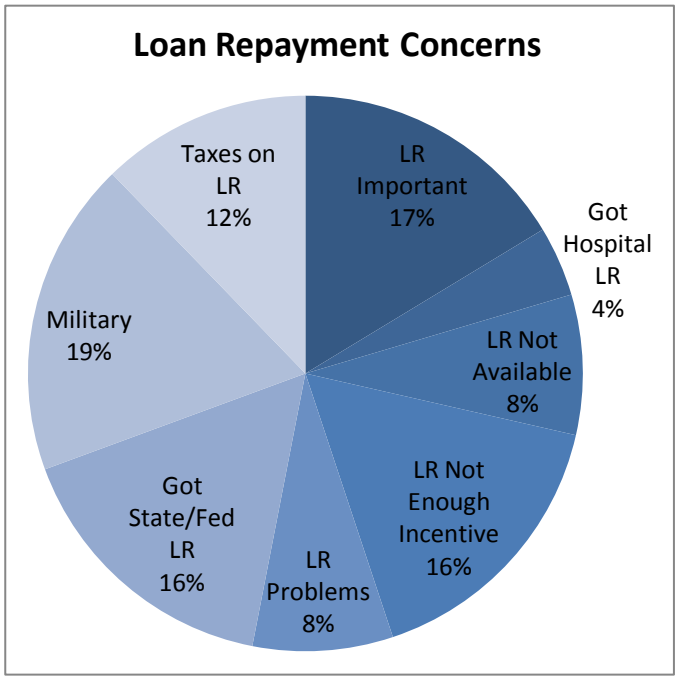
The next most commonly occurring code was rural practice hardships (14 times). This included such comments as "I don't think a lot of physicians will want to travel to satellite clinics every day," and "I practiced 11 years in a small town – first 4 years without a decent night's sleep – there are reasons some areas lack physicians and it is more lifestyle or lack of it than money." The next most common concern was the need for more or better rural recruitment efforts (13 times). Several physicians also pointed out they are not in general practice (11 times, i.e. administrators, emergency room, academic, etc.) but this should not be construed as a major concern, unlike concerns over too few family physicians (11 times) and gaps in rural health care (9 times). Student loans and loan repayment programs were also frequent topics for comment, perhaps due to the immediately preceding survey questions concerning them. For a full list of codes, see the Concerns of Family medicine Physicians bar chart in the Appendices, p. 33. Comments from Medicare certified rural health clinic physicians were not separated out for this analysis.

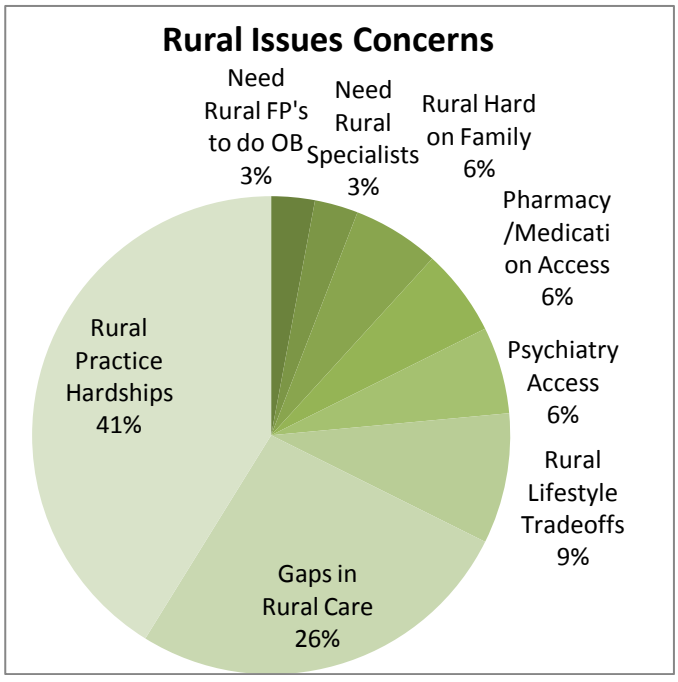


In general, comments could be broken down in the six categories. The categories for Loan Repayment and Rural Issues could then be further broken down for a more detailed understanding. Many respondents simultaneously said that loan repayment was important but that it was not enough incentive for a rural practice. A few also detailed problems they had with loan repayment, such as penalties when they lost their qualification before completing their repayment term. Many were frustrated by the fact that loan repayment funds count as taxable income, greatly reducing their effectiveness. Several physicians received financial assistance through the military, especially those who completed medical school in the 1950's to the 1970's.

Most rural lifestyle hardships centered around lower pay, longer working hours, being on call and lack of call sharing, finding replacements when physicians want to retire, and issues concerning the local hospitals and emergency departments.







Conclusions

Most family medicine physicians don't have any intention of leaving their practices, but many are very concerned about the continuation of family medicine in general and in rural areas in particular. If we take the higher percentage of practices recruiting in rural areas as an indication, physicians are already aware of a shortage of family medicine physicians. Some are also recruiting physician's assistants and nurse practitioners, but the focus appears to be on physicians.

Providing obstetric practice in rural areas is difficult for family medicine physicians because of the lack of support. Many no longer have the capability to perform C-sections under anesthesia and local hospitals are either too far away or are themselves able to provide only basic obstetric care. Some also cited hostility from local OB/GYN's. Practicing obstetrics is also detrimental to a physician's lifestyle, especially in rural areas where they essentially find themselves on call 24/7 with very little help. Physicians often cease providing obstetric care when they reach a certain age, sometimes passing it off to younger partners. Others discontinue in order to spend more time with their own families. Family medicine physicians in urban areas on the other hand often find that there are more than enough OB/GYN specialists to go around and their services are unnecessary. Physicians in both areas cited a decline in the demand for such services, sometimes to the point where they didn't feel they could keep the necessary skills in practice.

Most physicians seem to believe that availability of health care is more of a serious problem in rural areas than affordability. Physicians generally perceived these problems as serious or very serious and rural physicians were more likely than their urban counterparts to see them as such. In some cases physicians complained about a rise in the number of Medicaid and Medicare patients, of whom they had negative perceptions, generally believing them to be irresponsible and abusive of the system.

Generally, physicians who received loan repayment found it to be an important factor in their decision to practice in rural areas. However, several physicians who did not receive loan repayment also responded to the question and many felt that it was not an important enough factor to convince them to practice in rural areas given other perceived hardships.

The comments section revealed that many physicians feel that the long hours and low pay make rural practice less appealing than urban practice. Others pointed out that there are drawbacks particular to physicians with families, such as the inability of physician's spouses (especially if both are physicians) to find jobs in the same area, or the lack of opportunities offered by local schools for their children. All in all, many physicians didn't feel that loan repayment was enough of an incentive to practice in rural areas given the lifestyle tradeoffs.

Otherwise, low pay seemed to the greatest drawback to family medicine physicians. Physicians frequently asked why new graduates should go into family medicine when they can make more as specialists doing procedures with higher reimbursement rates.

Those two issues – rural lifestyle and low pay – are of greatest concern. The impact that DHHS and the Office of Rural Health can have may be limited, but loan repayment could go a long way to helping. Physicians were dissatisfied by the fact that loan repayment is taxable, limited to certain areas, requires a great deal of paperwork for a complicated application process, and can include penalties if the applicant loses his or her eligibility. The Office of Rural Health can also work with communities that are recruiting to find eligible applicants and to help cities and towns make themselves more appealing.

Further analysis can be done to on this survey and future research to clarify the situation and help support various plans of action.

Appendices

Breakdown by location charts may have slightly different percentages due to a zip code discrepancy between the Rural Urban Commute Area (RUCA) codes and the full list of 755 physicians. Only 731 physicians could be assigned a RUCA code and the remaining 24 we omitted from the calculations. These charts are for comparison purposes only. This omission does not affect the statistics for Medicare certified rural health clinic physicians.

Table 1.0 Gender												
All FP Physicians			Respondents		Metropolitan		Micropolitan		Small Town		Rural	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Physicians	561	194	276	115	258	112	113	28	111	28	79	26
Percentage	74%	26%	71%	29%	70%	30%	80%	20%	80%	20%	75%	25%
Discrepancy			-3.7%	3.7%	-5%	5%	6%	-6%	6%	-6%	1%	-1%

Table R1.0 Gender				
Medicare Certified Rural Health Clinic Family Medicine Physicians				
	All Certified Clinics		Respondents	
	Male	Female	Male	Female
Physicians	113	32	67	14
Percentage	78%	22%	83%	17%
Discrepancy	4%	-4%	4.8%	-4.8%

Table 2.0 Age											
	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	≥ 71	unknown
Physicians	15	73	111	96	120	127	104	71	20	13	5
Percentage	2%	10%	15%	13%	16%	17%	14%	9%	3%	2%	1%

Table R2.0 Medicare certified rural health clinic Physicians Age										
	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	≥ 71
Physicians	3	19	17	23	25	20	16	16	3	3
Percentage	2%	13%	12%	16%	17%	14%	11%	11%	2%	2%

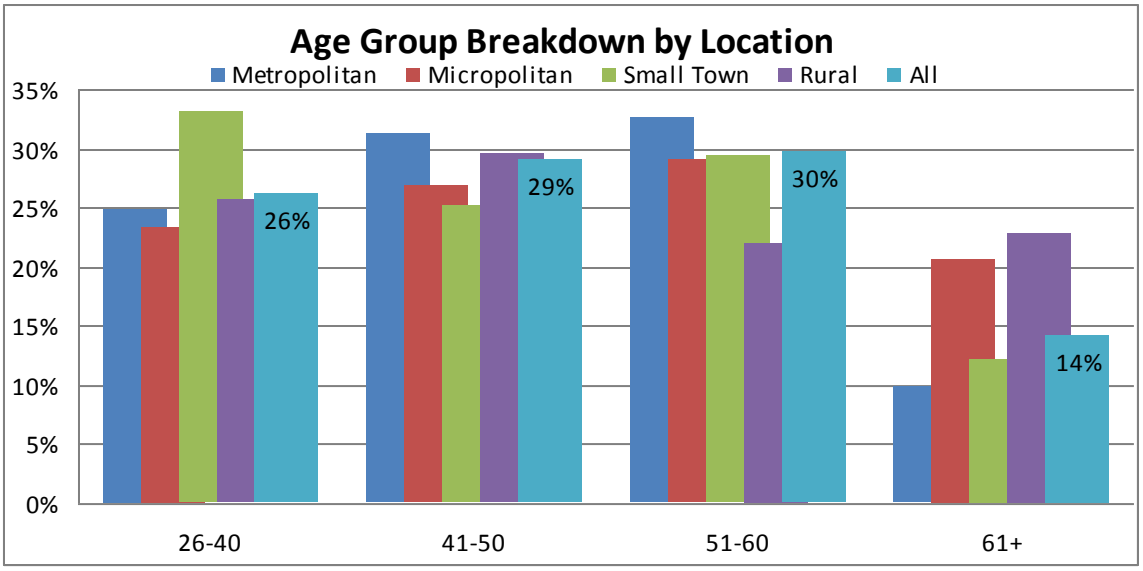


Table 3.0 Ethnicity

	White/ Caucasian	African American	Hispanic/ Latino	East Asian	Central Asian	Native American	Other	No Response
Physicians	612	7	16	19	8	2	63	28
Percentage	81.1%	0.9%	2.1%	2.5%	1.1%	0.3%	8.3%	3.7%

Table 3.1 Ethnicity as Compared to Nebraska Population

	White/ Caucasian	African American	Hispanic/ Latino	Asian	Native	Other/ None
Physicians	81.1%	0.9%	2.1%	3.6%	0.3%	12.1%
Population*	90.5%	4.1%	7.3%	1.6%	0.8%	0.0%

* U.S. Census Bureau American Community Survey 2005-2007 3-Year Estimates Nebraska Demographic Data Set

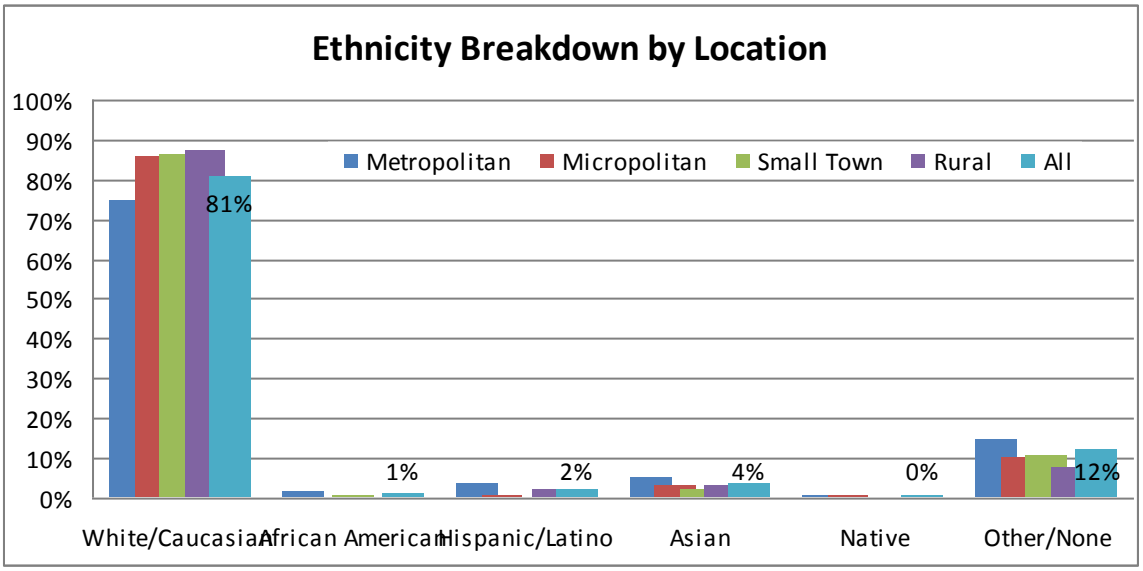


Table 4.0 Practice Location

	Metropolitan	Micropolitan	Small Town	Rural
Persons	333	65	219	268
Percentage	38%	7%	25%	30%

RUCA 2.0 Codes
Metropolitan = Population > 50,000
Micropolitan = 10,000 < Population < 49,999
Small Town = 2,500 < Population < 9,999
Rural = Population < 2,499

Practice Location of Respondents

	Metropolitan	Micropolitan	Small Town	Rural
Persons	159	85	74	73
Percentage	41%	22%	19%	19%
Discrepancy	+3%	+15%	-6%	-11%

Table 4.1 Location as Compared to Nebraska Population

	Metropolitan	Micropolitan	Small Town	Rural
Physicians	38%	7%	25%	30%
Population*	43%	8%	6%	42%

*U.S. Census Bureau 2000 Decennial Census

Table 5.0 Location Arrangement

	Salaried					Self-Employed			
	Federal Gov.	State Gov.	Group Health Plan	Hospital	Military	Partnership or Group	Solo Practice	Physician Network	Other/ Unkwn
Physicians	5	34	12	147	4	374	59	37	83
Percentage	0.7%	4.5%	1.6%	19.5%	0.5%	49.5%	7.8%	4.9%	11.0%

Table R5.0 Location Arrangement Medicare certified rural health clinic Physicians

	Salaried		Self-Employed			
	Group Health Plan	Hospital	Partnership or Group	Solo Practice	Physician Network	Other/ None
Physicians	1	67	48	8	8	1
Percentage	0.8%	50.4%	36.1%	6.0%	6.0%	0.8%

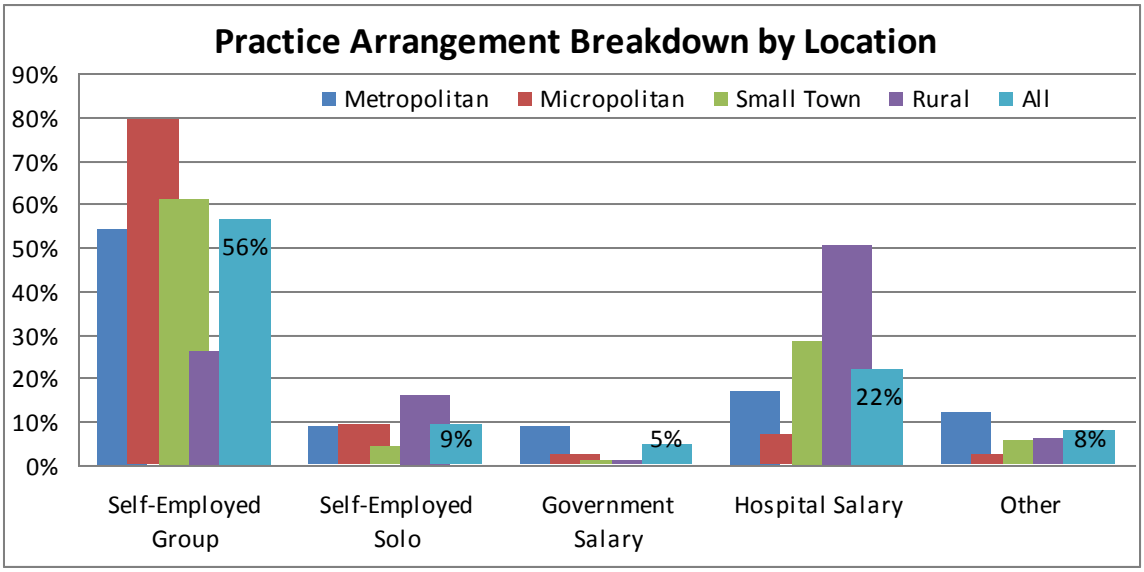


Table 6.0 Practice Setting

	Free Standing Clinic	Hospital Clinic	Office	Inst/ Facility	Academic	Admin.	Urgent Care	Other/ Unknown
Physicians	485	96	76	15	6	6	8	48
Percentage	64%	13%	10%	2%	1%	1%	1%	6%

Table R6.0 Practice Setting

	Free Standing Clinic	Hospital Clinic	Office	Admin.
Physicians	80	52	6	1
Percentage	11%	7%	1%	0%

Table 7.0 Professional Status

	Full-Time	Part-Time (<=29 hrs/wk)	Part-Time (30-39 hrs/wk)
Physicians	614	82	56
Percentage	81%	11%	7%

Table R7.0 Professional Status

	Full-Time	Part-Time (<=29 hrs/wk)	Part-Time (30-39 hrs/wk)
Physicians	112	18	14
Percentage	78%	12%	10%

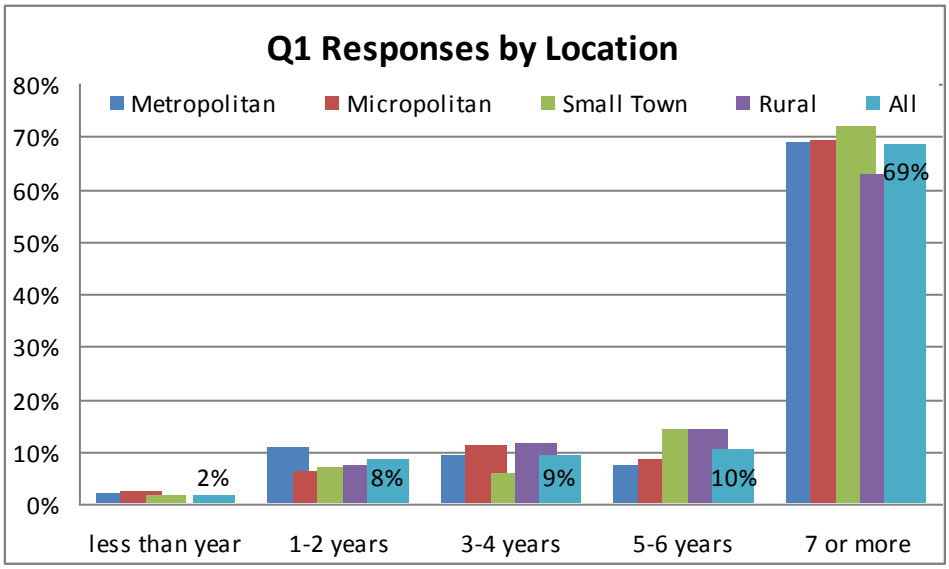
Q1: How much longer do you expect to practice in your current location?

	Less than year	1-2 years	3-4 years	5-6 years	7 or more	N/A
Persons	6	31	35	42	267	9
Percentage*	2%	8%	9%	11%	70%	

* N/A excluded

RQ1: Medicare certified rural health clinic physicians						
	less than year	1-2 years	3-4 years	5-6 years	7 or more	N/A
Persons	0	5	8	9	57	2
Percentage*	0.0%	6.3%	10.1%	11.4%	72.2%	

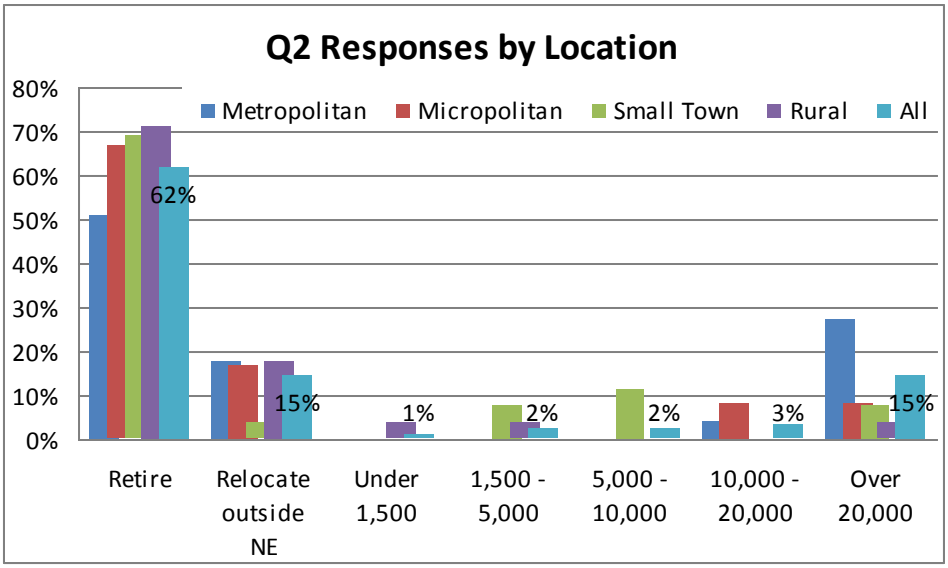
* N/A excluded



Q2: If you plan to discontinue practicing in your current location within the next five years, will you:								
	Retire	Relocate outside NE	Under 1,500	1,500 – 5,000	5,000 – 10,000	10,000 - 20,000	Over 20,000	N/A
Persons	85	20	1	3	3	4	19	253
Percentage*	63%	15%	1%	2%	2%	3%	14%	

* N/A Excluded

RQ2: Medicare certified rural health clinic physicians								
	Retire	Relocate outside NE	Under 1,500	1,500 - 5,000	5,000 - 10,000	10,000 - 20,000	Over 20,000	N/A
Persons	17	4	1	1	1	0	2	54
Percentage*	65%	15%	4%	4%	4%	0%	8%	



Q3: Is your practice currently recruiting additional practitioners?												
	Of all practices:					Of practices recruiting:						
	No	Yes	physicians	PA	NP	physicians only	physicians & PA	physicians & NP	PA only	PA & NP	NP only	Physician PA, NP
Persons	227	156	136	51	30	93	21	3	9	2	6	18
Pertct	59%	41%	36%	13%	8%	60%	13%	2%	6%	1%	4%	12%

Q4: Have you recently changed your obstetrics practice, or do you anticipate changing it within the next year?						
	Never Provided	No Change	Yes, have discontinued	Yes, plan to discontinue	Yes, plan to provide	N/A
Persons	80	135	140	20	5	10
Percentage*	21%	36%	37%	5%	1%	

*N/A Excluded

RQ4: Medicare certified rural health clinic physicians						
	Never Provided	No Change	Yes, have discontinued	Yes, plan to discontinue	Yes, plan to provide	N/A
Persons	7	40	24	4	2	3
Percentage*	9%	52%	31%	5%	3%	

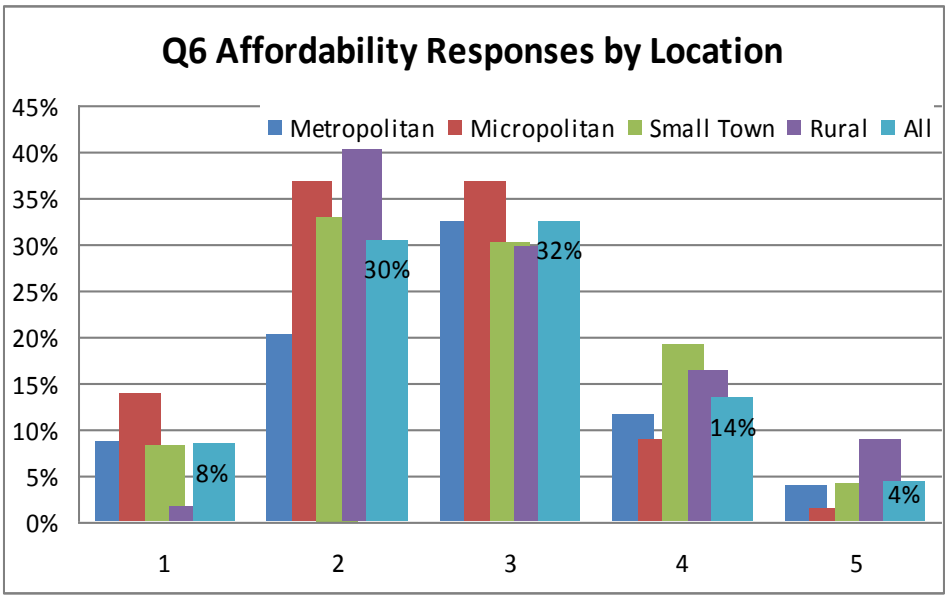
*N/A Excluded

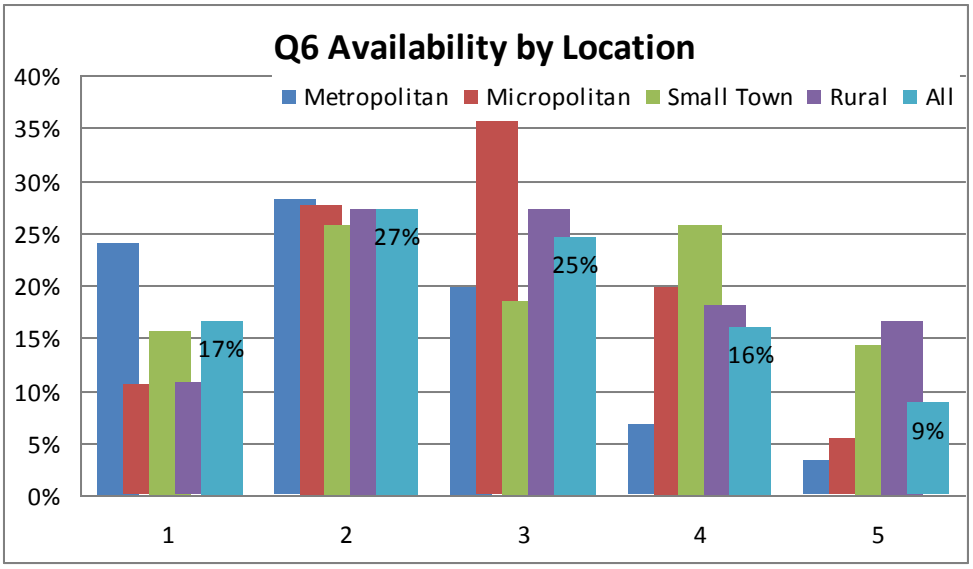
Q6: Based on your own experience, how serious are the problems of access to health care in rural Nebraska due to affordability and availability?					
	Affordability	Availability	Rated Responses	Unsure	N/A
Average*	3.17	3.07	646	64	18
*excludes Unsure and N/A				9%	

RQ6: Medicare certified rural health clinic physicians			
	Affordability	Availability	Rated Responses
Clinic Physicians	2.70	2.89	77
All Physicians	2.72	2.70	322

Q6a: Affordability					
Rating	1	2	3	4	5
Physicians	31	110	116	49	16

Q6b: Availability					
Rating	1	2	3	4	5
Physicians	58	94	85	55	30

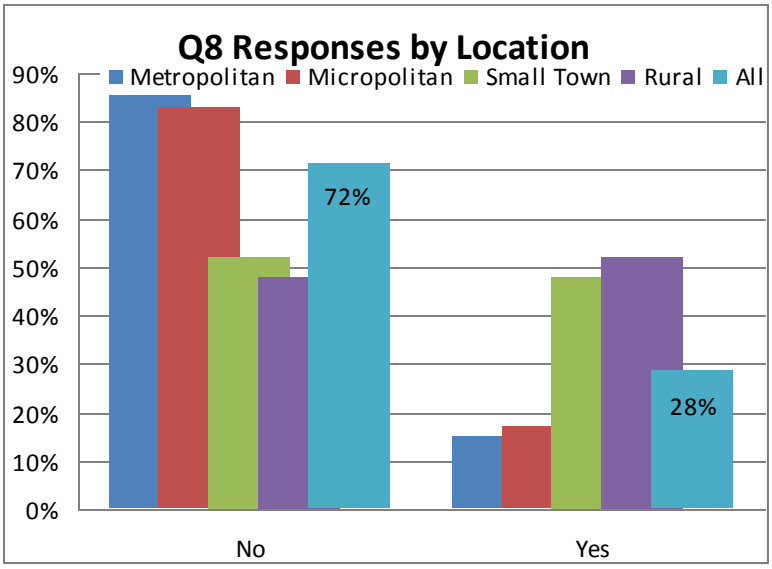




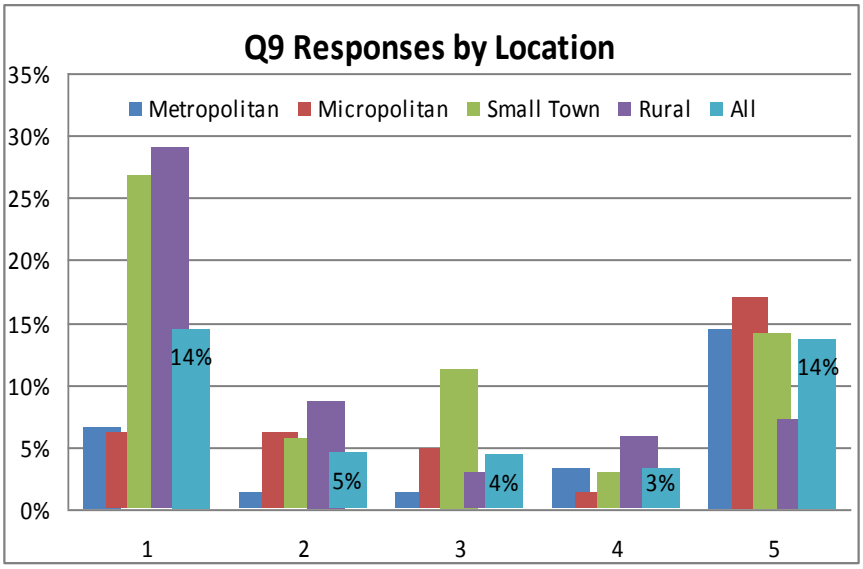
RQ7: Medicare certified rural health clinic physicians compared to all family medicine physicians		
	Clinic Physicians	All Physicians
Average Actual Debt	$ 60,931.51	$ 53,397.89
Inflation Adjusted Average in 2009 $	$ 112,121.78	$ 89,735.63

Q8: Did you receive state or federal loan repayment assistance for your medical school loans?		
	No	Yes
Persons	276	111
Percentage	71%	29%

Q8: Physicians Who Received LR Currently Practice In:	
Location	Physicians
Metropolitan	32
Micropolitan	24
Small Town	0
Rural	55

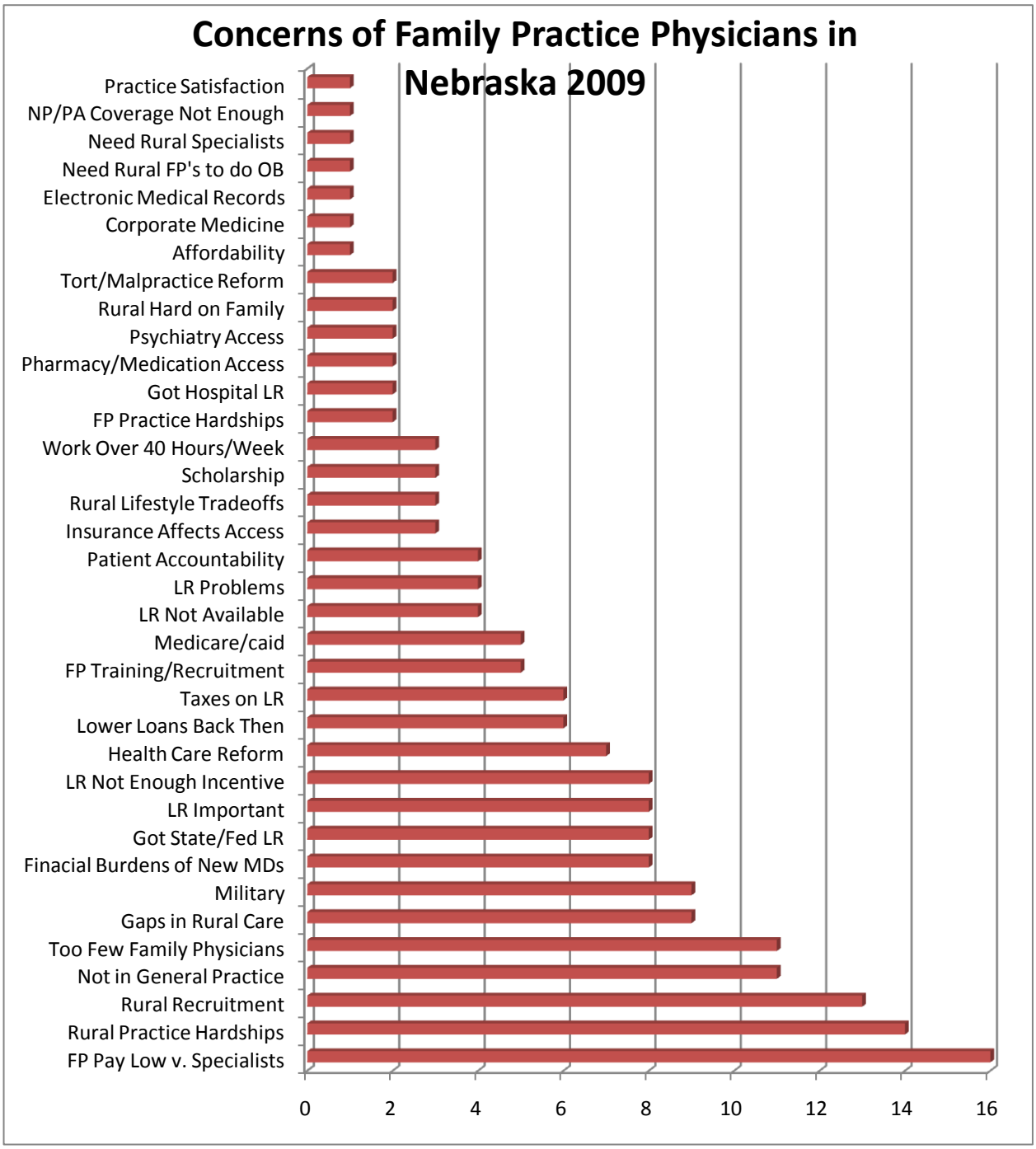


Q9: How important was loan repayment in your decision to practice at your first location after residency?	
Average	2.95
Marked No on Q8, but answered Q9 anyway.	
Persons	26
Percentage	17%
Among those who received loan repayment:	
Average	2.38



RQ9: Medicare certified rural health clinic physicians compared to all family medicine physicians.	
	Average
Clinic Physicians	2.18
All Family Medicine Physicians	2.95

Q9a Importance of Loan Repayment to Location Choice Among Recipients					
Rating	1	2	3	4	5
Physicians	52	15	11	8	22


Concerns of Family Practice Physicians in Nebraska 2009
Practice Satisfaction
NP/PA Coverage Not Enough
Need Rural Specialists
Need Rural FP's to do OB
Electronic Medical Records
Corporate Medicine
Affordability
Tort/Malpractice Reform
Rural Hard on Family
Psychiatry Access
Pharmacy/Medication Access
Got Hospital LR
FP Practice Hardships
Work Over 40 Hours/Week
Scholarship
Rural Lifestyle Tradeoffs
Insurance Affects Access
Patient Accountability
LR Problems
LR Not Available
Medicare/caid
FP Training/Recruitment
Taxes on LR
Lower Loans Back Then
Health Care Reform
LR Not Enough Incentive
LR Important
Got State/Fed LR
Finacial Burdens of New MDs
Military
Gaps in Rural Care
Too Few Family Physicians
Not in General Practice
Rural Recruitment
Rural Practice Hardships
FP Pay Low v. Specialists
0
2
4
6
8
10
12
14
16

2009 Family Practice Physician Survey

We are using the label with your name to assist with demographic variables we already have; none of your individual information will be shared as all data will be aggregated to assure your anonymity.

1. How much longer do you expect to practice in your current location?

☐ Less than a year ☐ 1-2 years ☐ 3-4 years ☐ 5-6 years ☐ 7 or more years

2. If you plan to discontinue practicing in your current location within the next five years, will you:

☐ Retire ☐ Relocate your practice outside Nebraska

☐ Relocate your practice within Nebraska
– **if so, to what size community?**
☐ Under 1,500 ☐ 1,500 – 5,000 ☐ 5,000 – 10,000
☐ 10,000 – 20,000 ☐ Over 20,000

3. Is your practice currently recruiting additional practitioners?

☐ No ☐ Yes - **If yes, which? Check all that apply:**

☐ physicians ☐ physician assistants ☐ nurse practitioners

4. Have you recently changed your obstetrics practice, or do you anticipate changing it within the next year?

☐ Have never provided OB care
☐ No change – plan to continue OB care
☐ Yes, have discontinued OB care
☐ Yes, plan to discontinue OB care
☐ Yes, plan to begin providing OB care

5. If you have discontinued providing OB care, please state the reason(s):

_____

_____

(Continued on Back)

6. Based on your own experience, how serious are the problems of access to health care in rural Nebraska due to affordability and availability:

	Very Serious……Not at all Serious					Unsure
Affordability	**1**	**2**	**3**	**4**	**5**	8
Availability	**1**	**2**	**3**	**4**	**5**	8

7. How much money did you owe upon completing your residency training?

_____

8. Did you receive state or federal loan repayment assistance for your medical school loans?

☐ No – **If no, skip to question 10** ☐ Yes

9. How important was loan repayment in your decision to practice at your first location after residency?

	Very important……Not at all Important				
Loan Repayment	**1**	**2**	**3**	**4**	**5**

10. Please feel free to comment on any issues you feel this survey has raised or overlooked:

_____

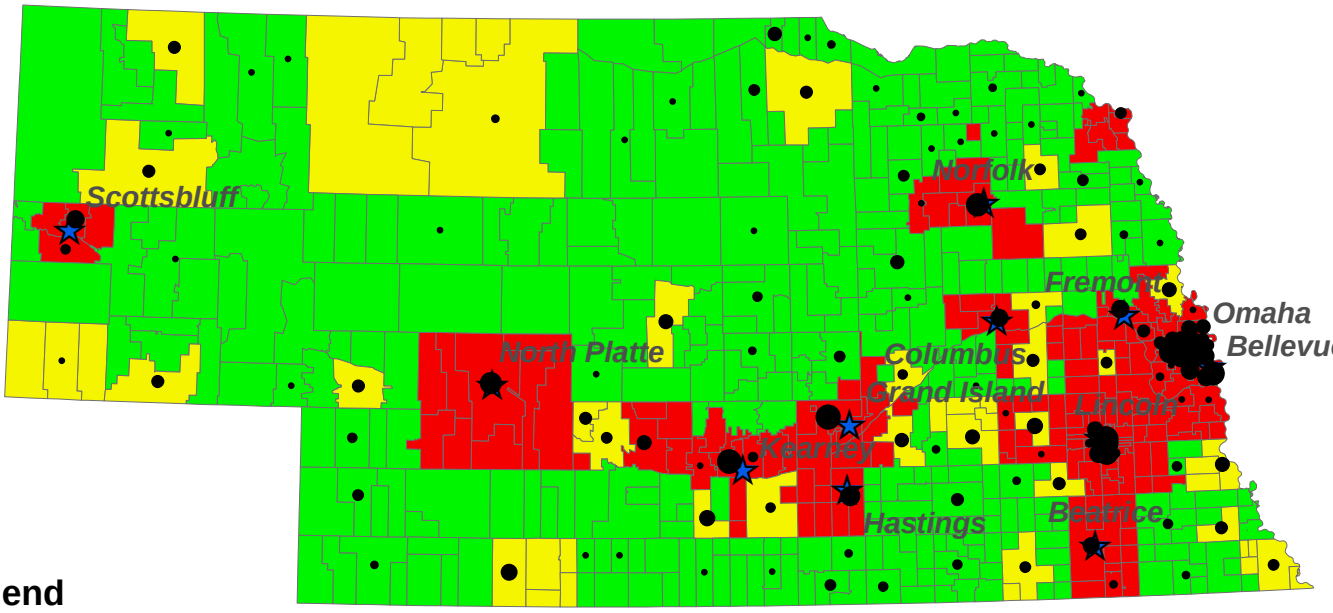
_____

_____

THANK YOU FOR PARTICIPATING IN THIS SURVEY.

This survey is being conducted by the Nebraska Office of Rural Health, P.O. Box 95026, Lincoln, NE 68509, (402) 471-2337. Only aggregated information will be shared, no individual identifiable information will be released. A summary of the survey findings will be made available to you.

Nebraska Family Medicine Physicians 2009



Legend

Commute Area Code

- Urban (Metro + Micropolitan)
- Small Town Rural
- Isolated Rural

Doctors per Zip Code

- 1
- 2.5
- 5
- 7.5
- 10

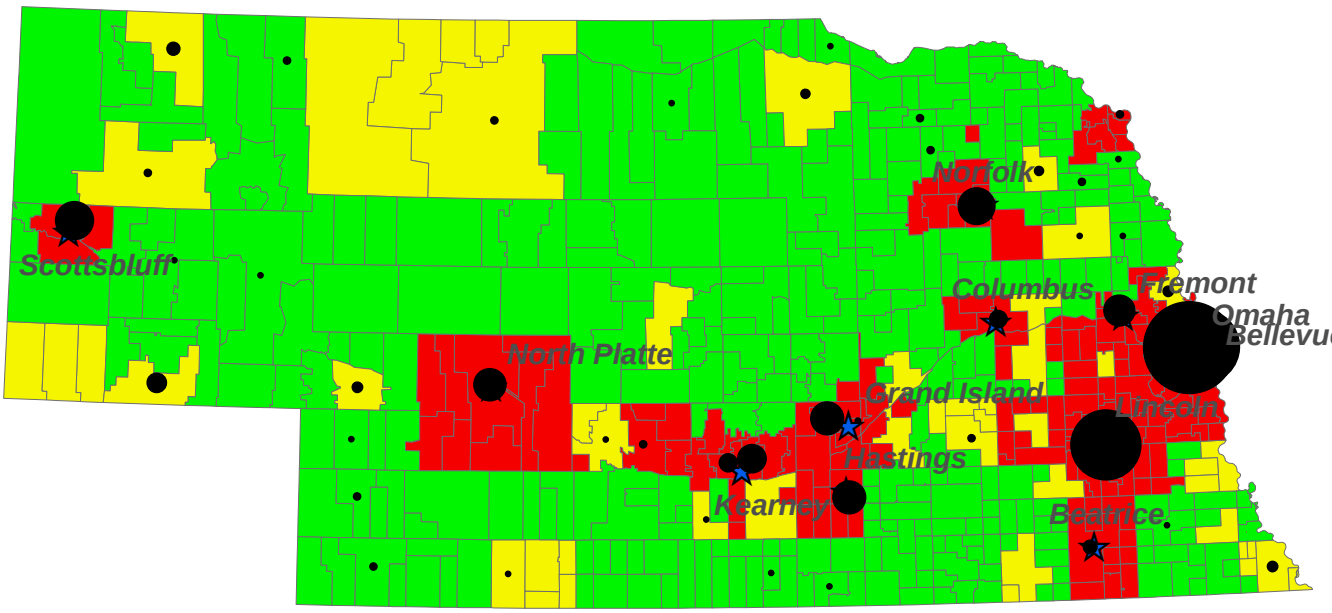
Dot located at center of zip code. Does not indicate actual doctor location.

0 20 40 80 120 160 Miles

N

by Monica Saford, Community Planning Intern & Thomas Rauner, PCO Director,
Office of Rural Health, Nebraska Department of Health & Human Services
November 20, 2009

Nebraska Specialist Physicians 2009



				Gender		Age										
	Population	RUCA	Doctors	Male	Female	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	71+	UNKNOWN
Percentage of State Total																
Metropolitan	53%	1 to 3.9	47%	44%	56%	53%	45%	44%	51%	51%	51%	53%	31%	30%	46%	100%
Micropolitan	20%	4 to 6.9	19%	21%	15%	7%	9%	24%	20%	16%	18%	20%	30%	30%	15%	0%
Small Town	11%	7 to 9.9	19%	20%	15%	33%	25%	22%	16%	17%	20%	17%	20%	10%	8%	0%
Rural	16%	10 & up	14%	15%	14%	7%	22%	10%	14%	16%	11%	10%	20%	30%	31%	0%
Percentage of Section Sum (N/A excluded)																
Metropolitan				70%	30%	2%	9%	14%	14%	17%	18%	15%	6%	2%	2%	1%
Micropolitan				80%	20%	1%	4%	18%	13%	13%	16%	13%	15%	4%	1%	0%
Small Town				80%	20%	4%	12%	17%	11%	14%	18%	12%	10%	1%	1%	0%
Rural				75%	25%	1%	14%	10%	12%	17%	12%	10%	13%	6%	4%	0%
All				74%	26%	2%	9%	15%	13%	16%	17%	13%	10%	3%	2%	1%
Discrepancy from State Average (All)																
Metropolitan				-5%	5%	0%	0%	-1%	1%	1%	1%	2%	-3%	-1%	0%	1%
Micropolitan				6%	-6%	-1%	-5%	4%	0%	-2%	-1%	0%	5%	2%	0%	-1%
Small Town				5%	-5%	2%	3%	2%	-2%	-1%	1%	-2%	0%	-1%	-1%	-1%
Rural				1%	-1%	-1%	5%	-4%	-1%	1%	-4%	-4%	4%	3%	2%	-1%

	Ethnicity																	
	White/ Caucasian	Vietnamese	Puerto Rican-Comwlth	Pakistani	Other Asian	Mexican Am/ Chicano	Japanese	Hispanic/ Other	Foreign	Filipino	Chinese	Black /African Amer.	Asian Indian	American Indian	Other	Unknown	NO RESPONSE	Multiple
Percentage of State Total																		
Metropolitan	44%	50%	67%	100%	33%	100%	100%	82%	100%	20%	67%	86%	100%	50%	0%	54%	67%	
Micropolitan	20%	25%	0%	0%	33%	0%	0%	9%	0%	40%	0%	0%	0%	50%	0%	17%	15%	
Small Town	20%	0%	0%	0%	0%	0%	0%	0%	0%	20%	33%	14%	0%	0%	0%	24%	4%	
Rural	16%	25%	33%	0%	33%	0%	0%	9%	0%	20%	0%	0%	0%	0%	100%	5%	15%	
Percentage of Section Sum (N/A excluded)																		
Metropolitan	75%	1%	1%	1%	0%	0%	0%	3%	0%	0%	1%	2%	2%	0%	0%	9%	5%	0%
Micropolitan	86%	1%	0%	0%	1%	0%	0%	1%	0%	1%	0%	0%	0%	1%	0%	7%	3%	0%
Small Town	86%	0%	0%	0%	0%	0%	0%	0%	0%	1%	1%	1%	0%	0%	0%	10%	1%	0%
Rural	88%	1%	1%	0%	1%	0%	0%	1%	0%	1%	0%	0%	0%	0%	1%	3%	4%	0%
All	81%	1%	0%	0%	0%	0%	0%	2%	0%	1%	1%	1%	1%	0%	0%	8%	4%	0%
Discrepancy from State Average (All)																		
Metropolitan	-6%	0%	0%	0%	0%	0%	0%	1%	0%	0%	0%	1%	1%	0%	0%	1%	2%	0%
Micropolitan	5%	0%	0%	0%	0%	0%	0%	-1%	0%	1%	-1%	-1%	-1%	0%	0%	-1%	-1%	0%
Small Town	5%	-1%	0%	0%	0%	0%	0%	-2%	0%	0%	1%	0%	-1%	0%	0%	2%	-3%	0%
Rural	7%	0%	1%	0%	1%	0%	0%	-1%	0%	0%	-1%	-1%	-1%	0%	1%	-5%	0%	0%

	Practice Type															
	Locum Tenens	OTHER	Partnership or Group	Physician Network	PRN	Salaried - Fed. Gov.	Salaried - Group Health Plan	Salaried - Hospital (non-Fed)	Salaried - Military	Salaried - Private	Salaried - State Gov.	Self-Emp - Partnership or Grp	Self-Emp - Solo Practice	Self-Emp-Partnership or Group	Self-Emp-Solo Practice Phy.	None
Percentage of State Total																
Metropolitan	0%	0%	75%	76%	0%	60%	67%	34%	100%	100%	86%	42%	45%	61%	33%	
Micropolitan	50%	0%	25%	0%	0%	0%	17%	6%	0%	0%	14%	30%	20%	9%	33%	
Small Town	50%	100%	0%	12%	0%	20%	8%	25%	0%	0%	0%	21%	7%	21%	33%	
Rural	0%	0%	0%	12%	100%	20%	8%	34%	0%	0%	0%	7%	29%	9%	0%	
Percentage of Section Sum (N/A excluded)																
Metropolitan	0%	0%	1%	9%	0%	1%	3%	17%	1%	0%	6%	46%	8%	7%	0%	0%
Micropolitan	1%	0%	1%	0%	0%	0%	2%	7%	0%	0%	2%	77%	8%	2%	1%	0%
Small Town	1%	1%	0%	3%	0%	1%	1%	29%	0%	0%	0%	56%	3%	6%	1%	0%
Rural	0%	0%	0%	4%	1%	1%	1%	51%	0%	0%	0%	23%	16%	3%	0%	0%
All	0%	0%	1%	5%	0%	1%	2%	22%	1%	0%	3%	51%	9%	5%	0%	0%
Discrepancy from State Average (All)																
Metropolitan	0%	0%	0%	4%	0%	0%	1%	-5%	1%	0%	3%	-4%	0%	2%	0%	0%
Micropolitan	0%	0%	0%	-5%	0%	-1%	0%	-15%	-1%	0%	-1%	26%	0%	-3%	0%	0%
Small Town	0%	1%	-1%	-2%	0%	0%	-1%	6%	-1%	0%	-3%	5%	-5%	1%	0%	0%
Rural	0%	0%	-1%	-1%	1%	0%	-1%	28%	-1%	0%	-3%	-27%	8%	-2%	0%	0%

	Q1						Q2							
	less than year	1-2 years	3-4 years	5-6 years	7+	N/A	Retire	Relocate outside NE	Under 1,500	1,500 - 5,000	5-10,000	10-20,000	20,000+	N/A
Percentage of State Total														
Metropolitan	50%	52%	40%	29%	41%	38%	33%	47%	0%	0%	0%	50%	74%	41%
Micropolitan	33%	16%	26%	18%	22%	25%	20%	21%	0%	0%	0%	50%	11%	24%
Small Town	17%	16%	11%	26%	20%	0%	23%	5%	0%	67%	100%	0%	11%	18%
Rural	0%	16%	23%	26%	17%	38%	25%	26%	100%	33%	0%	0%	5%	17%
Percentage of Section Sum (N/A excluded)														
Metropolitan	2%	11%	9%	7%	69%	2%	51%	18%	0%	0%	0%	4%	27%	66%
Micropolitan	2%	6%	11%	9%	70%	2%	67%	17%	0%	0%	0%	8%	8%	71%
Small Town	1%	7%	6%	14%	72%	0%	69%	4%	0%	8%	12%	0%	8%	63%
Rural	0%	7%	11%	14%	63%	4%	71%	18%	4%	4%	0%	0%	4%	59%
All	2%	8%	9%	10%	69%	2%	62%	15%	1%	2%	2%	3%	15%	65%
Discrepancy from State Average (All)														
Metropolitan	0%	2%	0%	-3%	1%	0%	-4%	1%	0%	-1%	-1%	0%	4%	1%
Micropolitan	1%	-2%	2%	-2%	1%	0%	-2%	0%	0%	-1%	-1%	1%	-3%	5%
Small Town	0%	-1%	-4%	4%	3%	-2%	4%	-4%	0%	2%	3%	-1%	-2%	-2%
Rural	-2%	-1%	2%	4%	-6%	2%	8%	2%	1%	1%	-1%	-1%	-4%	-6%

	Q3					Q4					
	No	Yes	physicians	PA	NP	Never Provided	No Change	Yes, have discontinued	Yes, plan to discontinue	Yes, plan to provide	N/A
Percentage of State Total											
Metropolitan	45%	34%	32%	26%	52%	71%	21%	45%	32%	20%	44%
Micropolitan	17%	29%	33%	32%	38%	14%	25%	22%	26%	60%	11%
Small Town	17%	21%	19%	30%	7%	4%	30%	15%	26%	0%	22%
Rural	21%	16%	17%	12%	3%	11%	23%	19%	16%	20%	22%
Percentage of Section Sum (N/A excluded)											
Metropolitan	44%	24%	19%	6%	7%	36%	19%	40%	4%	1%	3%
Micropolitan	24%	30%	29%	11%	7%	14%	41%	36%	6%	4%	1%
Small Town	33%	29%	23%	14%	2%	4%	59%	29%	7%	0%	3%
Rural	46%	24%	22%	6%	1%	12%	46%	37%	4%	1%	3%
All	37%	26%	23%	9%	5%	21%	36%	37%	5%	1%	3%
Discrepancy from State Average (All)											
Metropolitan	7%	-3%	-4%	-3%	2%	15%	-17%	4%	-1%	-1%	1%
Micropolitan	-13%	3%	6%	2%	2%	-7%	5%	-1%	1%	2%	-1%
Small Town	-4%	2%	0%	5%	-3%	-16%	23%	-7%	2%	-1%	0%
Rural	9%	-2%	-1%	-3%	-4%	-9%	10%	0%	-1%	0%	0%

	Q6a: Affordability						Q6b: Availability						Q8		Q9					
	Very Important <--> Not Important						Very Important <--> Not Important								Very Important <--> Not Important					
	1	2	3	4	5	Unknown	1	2	3	4	5	Unknown	No	Yes	1	2	3	4	5	N/A
Percentage of State Total																				
Metropolitan	38%	25%	37%	32%	33%	90%	53%	37%	29%	15%	14%	96%	48%	21%	19%	12%	13%	42%	43%	50%
Micropolitan	38%	27%	26%	15%	7%	3%	15%	23%	33%	28%	14%	4%	26%	13%	9%	29%	25%	8%	27%	24%
Small Town	21%	23%	19%	30%	20%	7%	20%	20%	16%	34%	34%	0%	14%	32%	35%	24%	50%	17%	20%	12%
Rural	3%	25%	18%	23%	40%	0%	13%	20%	22%	23%	38%	0%	12%	34%	37%	35%	13%	33%	10%	14%
Percentage of Section Sum (N/A excluded)																				
Metropolitan	9%	20%	33%	12%	4%	20%	24%	28%	20%	7%	3%	18%	85%	15%	7%	1%	1%	3%	14%	73%
Micropolitan	14%	37%	37%	9%	1%	1%	11%	28%	36%	20%	5%	1%	83%	17%	6%	6%	5%	1%	17%	65%
Small Town	8%	33%	30%	19%	4%	3%	16%	26%	19%	26%	14%	0%	52%	48%	27%	6%	11%	3%	14%	39%
Rural	1%	40%	30%	16%	9%	0%	11%	27%	27%	18%	17%	0%	48%	52%	29%	9%	3%	6%	7%	46%
All	8%	30%	32%	14%	4%	8%	17%	27%	25%	16%	9%	7%	72%	28%	14%	5%	4%	3%	14%	60%
Discrepancy from State Average (All)																				
Metropolitan	0%	-10%	0%	-2%	0%	12%	7%	1%	-5%	-9%	-5%	11%	14%	-14%	-8%	-3%	-3%	0%	1%	13%
Micropolitan	6%	6%	4%	-5%	-3%	-7%	-6%	0%	11%	4%	-3%	-6%	11%	-11%	-8%	2%	1%	-2%	3%	5%
Small Town	0%	2%	-2%	6%	0%	-6%	-1%	-2%	-6%	10%	6%	-7%	-19%	19%	12%	1%	7%	0%	0%	-21%
Rural	-7%	10%	-3%	3%	5%	-8%	-6%	0%	3%	2%	8%	-7%	-24%	24%	15%	4%	-1%	3%	-6%	-14%